DOCUMENT RESUME

ED 421 849 EC 306 622

AUTHOR	Krajicek, Marilyn J.
TITLE	Developing Policy and Practice for Implementation of the Individuals with Disabilities Education Act--Innovative Approaches to State and National Issues: Invasive Procedures. Final Report.
INSTITUTION	Colorado Univ. Health Sciences Center, Denver.
SPONS AGENCY	Special Education Programs (ED/OSERS), Washington, DC.
PUB DATE	1996-09-30
NOTE	235p.
CONTRACT	H029K30189
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01/PC10 Plus Postage.
DESCRIPTORS	Change Strategies; Elementary Secondary Education; Federal Regulation; *Inclusive Schools; *Interdisciplinary Approach; Mainstreaming; *Medical Services; Nurses; Policy Formation; *School Responsibility; *Special Health Problems; State Regulation
IDENTIFIERS	*Individuals with Disabilities Education Act; *Invasive Health Care Procedures

ABSTRACT

This final report discusses the activities and outcomes of a federally funded project designed to address the safe and legal implementation of the Individuals with Disabilities Education Act for young children who required invasive health care procedures. To accomplish the project objectives three annual, interdisciplinary conferences were held to explore the issues and present strategies for collaboration. Five domains for action were identified: the central role and needs of the children and family; the legal status of delegation in state practice acts; risk management; resource availability; and the changing fiscal climate. Recommendations for influencing systems that design and implement policy and practice on behalf of children with invasive health care needs include: (1) definition of goals and objectives; (2) identification of players; (3) establishment of coalitions; (4) engagement of all concerned parties; (5)consensus on the goals; (6) assessment of the full range of solutions; (7) addressing resistance to solutions; (8) prioritizing solutions; (9) definition of the framework for accomplishing the task; (10) careful use of contacts with legislators to be enlisted in the cause; and (11) periodic re-evaluation and modification. Appendices include the results of a national nurse practice acts survey, program brochures and follow-up evaluations. (CR)

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ED 421 849

DEVELOPING POLICY AND PRACTICE FOR IMPLEMENTATION OF THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

Innovative Approaches to State and National Issues: Invasive Procedures

PR/AWARD NUMBER
HO29K30189

U.S. DEPARTMENT of EDUCATION
OFFICE of SPECIAL EDUCATION and REHABILITATIVE SERVICES

FINAL REPORT

by

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September 30, 1996

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Final Report Program Narrative
PR/ Award Number HO29K30189
DEVELOPING POLICY AND PRACTICE FOR IMPLEMENTATION OF I.D.E.A.

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DEVELOPING POLICY AND PRACTICE TO IMPLEMENT INVASIVE HEALTH CARE PROCEDURES FOR YOUNG CHILDREN RELATED TO THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

RECOMMENDATIONS AND CONCLUSIONS

Policy and Practice Project
First Start Program
University of Colorado Health Sciences Center
School of Nursing
July 31, 1996

Executive Summary

The project on Developing Policy and Practice to Implement the Individuals with Disabilities Education Act (IDEA) related to Invasive Procedures for Young Children (Policy and Practice Project) was operated by the First Start Program, School of Nursing, University of Colorado Health Sciences Center, 1993-1996. The Project's objectives were to address issues of awareness, liability, and the need for training and information dissemination to assist compliance with federal mandates for inclusion, while confronting the discrepancy between the children's increasingly complex health care needs and declining resources to meet those needs.

Problem

Although federal policies mandate state movement toward inclusion of people with disabilities, realization of the mandate must be accomplished on the state and local levels, requiring the development of context appropriate policies and practices. As invasive health care procedures (e.g., clean intermittent catheterization, g-tube feeding, oxygen therapy, tracheostomy suctioning, and medication administration) are generally regarded as nursing tasks, a major contextual variable is the legality of delegating nursing tasks to unlicensed individuals, as determined in state practice acts, rules, and regulations (especially nurse practice acts). Thus, child care agencies and schools may have to choose between compliance with federal mandates and compliance with state laws. Even when delegation is allowed, the care of children who require invasive procedures is fraught with risk for the safety and wellbeing of the child, as well with the potential for liability of the agency or school and individuals delegating and performing the procedures.

Methods and Outcomes

To accomplish the project objectives three annual, interdisciplinary conferences were held to explore the issues and present strategies for collaboration, adopting a *process* orientation to assisting state and local solutions. Five domains for action and recommended strategies were identified:

1. The central role and needs of the child and family, requiring:
    a. family-focused and family-directed service delivery models;
    b. multidisciplinary service provision in natural settings;
    c. age- and developmentally-appropriate practices in school settings;
    d. discernment of support strategies that individual families perceive as helpful.

2. The legal status of delegation in state practice acts, requiring:
    a. up-to-date information on state practice acts, rules and regulations to determine the permissibility of and limitations imposed upon delegation of invasive health care procedures to unlicensed, assistive personnel;

b. amendment of the practice acts that prohibit delegation if adequate nursing resources are not available;
c. laws that will accommodate the rapid pace of technological advances and serve the children, families and practitioners;
d. sharing of information on the legal status of delegation to alert the public, parents, administrators, professionals in diverse disciplines, and paraprofessionals to encourage dialogue toward the assurance of safe and legal care.

3. Risk management, requiring:

a. proactive policies defining parameters for inclusion and exclusion;
b. delegation protocols in compliance with state medical and nurse practice acts and regulations that are suited to the context (state and local variables).
c. guidelines for standards of care for the specific procedures to be accommodated that are compatible with the context of application;
d. assessment and methods for addressing training needs for professionals and unlicensed individuals who may perform invasive procedures;
e. explicit procedures and timeframes for supervision and monitoring, both for the individual delegate, and for the overall system (adherence to and outcomes of policy, standards, training and supervision) to evaluate the success of the system in serving the goals of safe and legal inclusion.
g. judicious use of delegation only when circumstances indicate that delegation of an invasive procedure to an unlicensed person will not jeopardize the health and safety of the child.

4. Resource availability, requiring:

a. research to identify useful existing resources;
b. adaptation of models to address unique state and local variables (political climate, interdisciplinary relationships, practice acts, funding mechanisms, and so on);
c. development of state and interstate formal and informal networks of colleagues for information and resource exchange;
d. creative interdisciplinary and interagency solutions.

5. Changing fiscal climate: block granting of Medicaid and consolidation of the health care provider-payer markets, requiring:

a. establishment of relationships with the policy makers for state block grant Medicaid programs;
b. maintenance of a presence with policy makers even after initial policies are determined to influence program modifications;

c. advocacy for retention of Medicaid eligibility for children below the poverty line for developmentally-appropriate services so long as medically justified;
d. maintenance and sharing of up-to-date knowledge as to philosophies, structures, and consequences of the health care payer-provider systems (educate policy makers and consumers);
e. awareness of interrelatedness of human service systems and resulting ripple effects of change.
f. organizing or joining with other child advocates to ensure that the needs of children who require invasive procedures are appropriately and fairly addressed.

Strategies to address unresolved issues, including reauthorization of IDEA and continuing debate as to "medical" versus "health" or "related" services require methods and resources for keeping current with:

a. changes on the federal laws impacting children with special health care needs;
b. court decisions affecting the delivery of special education services.

Influencing systems that design and implement policy and practice on behalf of children with invasive health care needs requires:

a. definition of goals and objectives, with revisions as needed;
b. identification of the players and their interests in the issue;
c. establishment of coalitions with relevant power and influence;
d. engagement of all of the concerned parties, including those with dissenting points of view;
e. consensus on the goals before initiating the legislative process;
f. assessment of the full range of solutions
g. addressing resistance to solutions;
h. prioritizing to solutions
i. definition of the framework for accomplishing the task;
j. careful use of contacts with legislators and others to be enlisted in the cause.
k. periodic re-evaluation and modification of the entire process.

Conclusions

Development of policies and practices for safe and legal implementation of IDEA for young children who require invasive health care procedures must address complicated issues of conflicting laws, resource discrepancies, and increasingly complex health and medical issues. Compared to the situation in schools, the problem may be even more difficult in the relatively less regulated arena of child care, warranting a major campaign of public (consumer and provider) education in the issues. Education of consumers, providers and policy makers as to compromises made in service access, availability and quality in attainment of healthcare cost-efficiencies must also occur, as children with chronic illnesses and disabilities are likely to be seriously impacted by such changes, along with other human service entities that serve these children.

Efforts to increase awareness of the implications of state medical and nurse practice acts for health, medical, education, and child care providers are essential. These laws are designed to protect the public and ensure the integrity of regulated professions. Graduates of Schools of Nursing, Medicine and Education (regular and special education, and early intervention) must understand the increasing complexity of the evolving child population, as well as the legislated articulation of professional roles in meeting the needs of these children. Interdisciplinary service models call for interdisciplinary education.

Finally, an ethical-moral framework is fundamental to guide decision-making amid these complex issues. Retention of a simple maxim is suggested when confronting the difficult decisions raised: all children should have the opportunity to participate in life, not merely observe.

I was afraid that life would pass her by; that she was destined to be an observer rather than a participant.
(Kit Hovey, regarding her daughter, a child with special health care needs)[1]

The project on Developing Policy and Practice to Implement the Individuals with Disabilities Education Act (IDEA) related to Invasive Procedures for Young Children (hereafter referred to as the Policy and Practice Project) was initiated by the First Start Program[2] of the University of Colorado Health Sciences Center in 1993[3]. The Project was intended to apprise state and local communities of issues in developing policy, procedures, and training opportunities to support implementation of IDEA for the benefit of young children with special health care needs for invasive procedures. Thus, the project addressed issues of awareness, liability, and the need for training and information dissemination to assist compliance with federal mandates for inclusion into the community of people with disabilities.

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[1] In remarks to the *First National Conference on Developing Policy and Practice to Implement the Individuals with Disabilities Education Act (IDEA) related to Invasive Procedures for Young Children*, June, 1994.

[2] First Start is a 10 year old project for the development of curricula and training models to prepare child care givers and early educators in the care of children with chronic illness and disabilities. First Start has been funded by a series of grants awarded by the U.S. Department of Education, Office Special Education and Rehabilitative Services, from 1985 to date).

[3] The Policy and Practice Project was sponsored by a grant awarded by U.S. Department of Education, Special Project H029K30189.

The Problem

The socio-political agenda for inclusion of children with special needs has been underway for more than 20 years. Inclusion of children with disabilities was an outgrowth of the civil rights movement that resulted in recognition of the minority status of individuals with disabilities (Bowe, 1995). Thus, the movement for community integration of children with special needs was scripted through the passage and amendment of a series of public laws, most notably, the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, and the 1990 Americans with Disabilities Act.

Together these laws benefit young children with special needs owing to chronic illness and disability by defining rights that: a) protect against discrimination, mandate entitlements to a free and appropriate education in the least restrictive environment possible, b) address identification and evaluation of health needs, and c) clarify parent and professional roles in planning processes for meeting those needs. Nonetheless, realization of this powerful federal scenario is dependent upon implementation of state and local-level policies, legislation, regulations, and practices.

During this same timeframe, advances in medicine and health care have enabled the survival and increased mobility of children who are medically fragile or dependent upon technology (Kohrman, 1992). The resulting population of child care- and school-age children is changing dramatically to include large numbers of children with complex health care needs. Among these conditions are needs for invasive health care procedures such as clean intermittent catheterization, g-tube feeding, oxygen therapy, tracheostomy suctioning, and medication administration--procedures that are typically regarded as the province of licensed health care providers.

A concurrent trend is the redefinition of school nurse functions (Harrison, Faircloth & Yaryan, 1995; National Council of State Boards of Nursing, 1991). Today, few school districts can fund a nurse in every building. Even on a consulting basis, ready access to nursing support is a luxury virtually unknown in child care settings. So that health status does not hinder inclusion, roles and responsibilities are being redefined by the pressures of scarce nursing resources and the increasing complexity of in-school health care needs. The roles and responsibilities that are being reformulated are not only those of school nurses but those of the educators, aides, child care professionals, bus drivers and support staff. When there is no nurse in the building, someone will perform the task.

Thus, child care programs and public schools are increasingly challenged by federal mandates. How can they educate children who require invasive health care procedures as access to nursing support dwindles?

In the absence of adequate nursing support, a common dilemma is the choice between two equally unappealing alternatives: deny admission to the least restrictive environment, or accept a child and make do with resources on hand, risking personal and agency liability if the child is harmed. Moreover, laws at the state level, such as Nurse Practice Acts, may complicate or explicitly prohibit the delegation of invasive tasks to unlicensed individuals.

A confusing issue is the fact that parents are taught to perform these tasks for their children and incorporate them into day-to-day life. Thus, when inclusion is denied because there is, for example, no nurse to feed a child, a parent will often volunteer to teach this "routine" task to an aide. However, the simple logic of the parental solution overlooks an essential distinction. Parents provide *gratuitous care* (care provided without remuneration by a family member or friend). Employees of a child care agency or school are paid for the services they provide to children in the course of their employment.

If the administrator agrees to permit parental instruction, and it's imperfect or incomplete, or an unanticipated response occurs, or the child's changing needs are not communicated, the greatest risks are the child's and the parents', followed by the aide and agency or school. Someone is practicing nursing without a license. If a nurse observes or instructs the aide, but the prevailing Nurse Practice Act prohibits delegation of the task, the nurse risks licensure and livelihood.

Daunting though these observations may be, they are realities. Another reality is that the children are increasingly in our communities and will continue to present for admission to facilities that are unprepared to meet their needs. Who will serve them? How may their needs for invasive health care procedures be met safely and legally? These are the crucial questions the Policy and Practice Project was designed to explore.

Project Direction

Policy and Practice Objectives

The stated objectives of the Policy and Practice Project were to:

- increase awareness of state leadership personnel of the need to examine legal obligations and constraints, their understanding of what the special health care needs are for infants and young children with complex medical needs, and their recognition of interagency cooperation needs to serve this special population in mainstream settings;
- examine and set forth appropriate laws, regulations, and standards for safe delegation of nursing tasks to non-health professionals and paraprofessionals; and
- provide training models and disseminate proceedings and resource guide to provide notification of availability of training to prepare personnel for safe, legal administration of invasive health care procedures.

Methodology

To accomplish these objectives, three national conferences were held annually from 1994 through 1996, in Denver, Colorado. Underlying the program designs was a conceptual model of policy as "macrodecision", a dynamic, evolving phenomenon enmeshed in networks of related activities resulting from a formal or informal multi-decision process (Burrian, 1989, p. 95). This paradigm is apropos to the implementation of IDEA related to invasive procedures where policy development occurs in multiple, sometimes overlapping domains in ongoing processes. Those charged with defining and implementing policy in one domain may discover their decisions conflict with those from other domains, including law, ethics, technology, health, education, and child advocacy, thus mandating a multidisciplinary exploration of the issues. Over the course of the project, the conference brought together representatives of nursing, medicine, education, child care, ethics, allied health professions, the law, finance, parent advocacy, administrative and regulatory agencies, and professional organizations to explore the issues and present strategies for collaboration. Thus, the conferences explored: the nature of the population of children with needs for invasive health care procedures and their families; the status of applicable laws; the standards of safe practice and delegation; the perspectives of diverse relevant disciplines; strategies for systems change; resources for technical assistance and funding; and, model programs. To further the dissemination objective of the project, summary proceedings of each conference (Krajicek & Steinke, 1995, 1996a, 1996b) were prepared and distributed nationally to Schools of Education with programs in early education, as well as to other interested parties.

Outcome Orientation

The challenge in developing policy and practice to implement IDEA on behalf of young children who require invasive health care procedures is to achieve inclusion when the discrepancy between declining resources and escalating needs seems irreconcilable. Early on in the Project, it became evident that there was no single formula or template applicable across the nation. Solutions would be achieved only on the state levels with regard for state and local contextual variables. Therefore, the emphasis of the project was on *process*.

The most significant outcomes emerging from the analysis of the accumulated presentations and discussions of the three year Policy and Practice Project are identification of major domains and unresolved issues, and a series of related strategy recommendations to achieve viable solutions at the state and local levels.

Recommendations by Domain

From the scores of presentations and discussions at the three Policy and Practice conferences (Krajicek & Steinke, 1995, 1996a, 1996b), five principal domains emerge that are critical to state and local solutions to ensure all aspects of preparedness to meet children's needs for invasive procedures. Each presents challenges to the ethical framework, philosophy, creativity and commitment of the parties invested in the consequences of decisions affecting inclusion of children who require invasive procedures. Strategies applicable within each domain are essential for achieving optimal conditions to foster safe and legal inclusion when invasive procedures are at issue.

The central role and needs of the child and family

Chief among the concerns of parent advocates participating in the Policy and Practice Project were the assertions that those serving their children must a) acknowledge the preeminent role of family and b) avoid pessimistic predictions about a child's future achievements that deny the child's individuality and personal resilience. A responsive service system regards the child as a member of a unique family, and then evaluates and serves the total child medically, developmentally, educationally, and psychosocially, without dwelling on deficits[4].

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[4] The perspectives of John Nackashi, MD PhD, University of Florida at Gainesville, who presented in all three years of the project, and Brian McNulty, PhD, Colorado Department of Education, who presented in 1994 and 1996, were especially valuable in the conceptualization of this domain and related strategies.

Strategies

1. Establish service delivery models that are:

   a. family-focused and family-directed (rather than child-focused), in recognition of the fact that families are systems in which intervention in one element affects the entire system.

   b. founded on the concepts of "ability" and "enablement" (rather than the "medical", "disability", or "deficit" model), reinforcing and capitalizing on child and family strengths, abilities, and assets.

2. Integrate services into natural settings. This may be achieved in a continuum of services that:

   a. provides multidisciplinary care of the whole child, and

   b. compels providers of eduction and care (professional, paraprofessional and parental) to learn to communicate, to share, and to collaborate for the benefit of the child and family.

3. Introduce age- and developmentally-appropriate practices (common in child care) in school settings, supplanting primary reliance on teacher-directed interventions.

4. Recognize and work with cultural differences between families. These differences are not limited to language and ethnic differences, differences of socioeconomic status, nor even disability as a differentiating factor. Respect for differences requires appreciation of the culture of the individual family and discernment of support strategies that the family perceives as helpful.

The legal status of delegation in state practice acts

Under the Individuals with Disabilities Education Act (IDEA), states must provide early intervention services to infants, toddlers and young children with special health care needs in child care centers, preschools, and public schools. Furthermore, IDEA requires that such services be provided in the least restrictive environment, which often means the same setting that the child would be placed in if the child had no special education or special health care needs.

Although IDEA mandates that a child be served in the least restrictive environment, the reality is that children with special health care needs that include invasive procedures may not be placed in such a setting due to the fact that licensed nursing care is not available on a regular basis in that particular setting. Some agencies have complied with IDEA but have acted contrary to the applicable state nurse or medical practice act by placing children with special health care needs in the least restrictive environment and authorizing unlicensed personnel to perform the required invasive procedure. Others have complied fully with the applicable state nurse practice act, allowing only licensed nursing personnel perform the invasive procedures, but at the cost of failing to meet the child's needs within the least restrictive environment mandate of IDEA. Children who require some type of invasive procedure to be performed in order to participate in the "regular" child care setting or preschool program are particularly vulnerable to being displaced or placed in a far more restrictive setting due to the availability of a licensed nurse in an alternative, albeit more restrictive, setting.

Agencies serving children with special health care needs, whether child care centers, preschools, or public schools, should not have to choose between compliance with the state's laws regulating nursing and medicine and compliance with the federal laws requiring children with special health care needs to be served in the least restrictive environment. For this reason, a priority of the Policy and Practice Project was education as to the requirements of individual state nurse practice acts, and specifically, whether the pertinent state's nurse practice act or the regulation promulgated pursuant to the act contains a "delegatory clause", i.e., language permitting the delegation of defined nursing functions to others (such as paraprofessionals, nurse aides, and the like).

In each of the three years of the Policy & Practice Project, a survey was conducted to determine whether delegation of nursing tasks to unlicensed assistive personnel was permitted under each of the fifty-one state nurse practice acts [the statute], including Washington, D.C. These surveys were based upon the statute, and in the later two years, the regulations promulgated under the statute, as provided by the board of nursing in each state.[5] (The 1996 survey results are presented in the Appendix.)

During the three year project, although there was a slight increase in the actual number of states that permitted delegation of nursing tasks to unlicensed personnel (27 in 1994, to 29 in 1996), the change could not be classified as a trend. More significant was the change in the number of states that did not permit delegation of any sort (21 in 1994, compared to 13 in 1996). The net change in this category is attributable primarily to the movement by a number of states from permitting no delegation whatsoever in 1994, to later permitting delegation to specified classes of medical personnel. These people were variously described as: "nursing assistants", "nurse aides", "qualified personnel", "licensed practical nurses" and similar terms. Some of these categories require licensing while others require only specific training or certification. In some cases the state nurse practice act was amended, in others the regulations promulgated under the act were modified to permit limited delegation.

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[5] The survey of Nurse Practice Acts was published in the conference materials provided to each attendee, In addition, survey results were presented by a licensed attorney who had analyzed each of the acts.

A few states developed guidelines for delivery of health care in specific settings such as public schools and public institutions for persons with developmental disabilities. These guidelines may contain protocols for specific nursing tasks and the criteria to be used for delegation of each identified task.

Overall, states appear to have become slightly more responsive to the special needs of children who require the performance of invasive procedures in order to be integrated into settings such as public schools and child care programs. While awareness of these needs and development of policies and practices to meet them were primary intents of the project, it is disconcertingly apparent that many administrators, educators, legislators, and medical service professionals lack basic understanding of the parameters imposed upon medical service delivery systems by their respective state professional acts such as nursing and medicine. Much education remains to be done.

Strategies

1. Acquire and maintain up-to-date information on state practice acts, rules and regulations to determine the permissibility of and limitations imposed upon delegation of invasive health care procedures to unlicensed, assistive personnel.
2. If delegation is not permitted, act to amend the practice act. Consider the prevalence of medication administration by principals, teachers, and aides who are utterly unaware of the illegality and risk of liability (unless the procedure is specifically exempted in the practice act). Consider the potentially dire consequences associated with mislabelled bottles, missed or double dosages, or administration of the wrong medication. The procedures are being performed in child care and schools daily by unlicensed individuals. At minimum, a delegatory clause affords the potential for establishment of safeguards (National Council of State Boards of Nursing, 1990).
3. Formulate laws that will not be obsolete in the short term. The passage and enactment of legislation is a slow process whereas the rapid pace of technological advances will likely escalate.
4. Share information on the legal status of delegation to alert the public, parents, administrators, professionals in diverse disciplines, and paraprofessionals to encourage dialogue toward the assurance of safe and legal care.

Risk management

The implementation of IDEA for children who require invasive procedures is fraught with decisions that incur risk. The risks accrue to the child and family, the delegating nurse, the child care agency or school, and employees who determine admissions and perform invasive health care procedures. Only through careful establishment of policy and adherence to well-defined safe standards of practice can the risks be minimized.

Strategies

1. Establish and follow a proactive policy that defines parameters for inclusion and exclusion. Although policy exceptions may be made (when rationales are thoroughly documented), reliance on case-by-case decision-making in lieu of an explicit policy constitutes unnecessary risk.
2. Develop a delegation protocol that is in compliance with state medical and nurse practice acts and regulations. Model resources are available to facilitate the process (for example, National Council of State Boards of Nursing, 1994a & b) but, models must be modified to account for context of application.
3. Develop guidelines for standards of care for the specific procedures to be accommodated that are compatible with the local setting, its resources and limitations (e.g., agency, district)(Consensus Committee of ANA, 1993).
4. Assess training needs for staff, paraprofessionals, aides, bus drivers, and others who may perform the invasive procedures and identify or develop appropriate programs to meet those needs.

5. Establish procedures and timeframes for supervision and monitoring. On the individual level, initial training in a delegated task must be followed by regular, ongoing professional (nursing) supervision. On the system level, monitor adherence to and outcomes of policy, standards, training and supervision to evaluate the success of the system in serving the goals of safe and legal inclusion.

6. Do not adopt a blanket delegation policy in which all invasive procedures are performed by unlicensed personnel. Recognize that the legality of delegation does not mandate that delegation occur in every case. When circumstances indicate delegation of an invasive procedure to an unlicensed person would jeopardize the health and safety of the child, delegation must be refused. Ethical dilemmas arise when threats to employment or other undue pressures are applied to try to force imprudent delegation. Refusal may cost a nurse a job, if however a task is delegated against better judgment and harm comes to the child, the nurse may lose licensure and livelihood.

Resource availability

The magnitude of the challenges to comprehend complex laws and their interactions, amend practice acts, and develop policies, protocols, standards and training programs may seem overwhelming--particularly if it is assumed that these endeavors require entirely new inventions. Many states, administrative agencies, programs and professional organizations have designed and implemented creative solutions and model programs or documents. Many state and federal agencies, and the program they sponsor, offer technical assistance and information on issues concerning young children, including those with disabilities and special health care needs[6]. Similarly, professional organizations, universities, and University Affiliated Programs[7], and private philanthropic foundations are excellent sources for models, educational materials, and other resources.

Strategies

1. Research existing models and technical assistance sources.[8] Due diligence will decrease wasted effort reinventing existing resources.
2. Recognize that even the best models require adaptation to account for differentiating contextual variations in such areas as political climate, history of interdisciplinary relationships, prevailing practice acts, funding mechanisms, and other variables that contribute to the unique nature of each state and locality.
3. Develop formal and informal networks of colleagues in one's own and other states for exchange of ideas and resource information.

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[6] For example, NEC*TAS, National Early Childhood Technical Assistance Systems, a consortium program based at the University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Center, is a program supported by the U.S. Department of Education, Office of Special Education Programs. Although created to provide technical assistance to state agencies implementing Part H and Section 619 of IDEA (including State Interagency Coordinating Councils) and Early Education Programs for Children with Disabilities, NEC*TAS will provide information and assistance to others (phone- (919)962-2001; FAX- (919)966-7463; Internet- nectasa.nectas@mhs.unc.edu).

[7] University Affiliated Programs, or UAPs, exist in every state. They are federally funded to address interdisciplinary training needs to improve services for people with disabilities.

[8] All three documents summarizing the Policy and Practice Conference *Proceedings* (1994 - 1996) contain descriptive and contact information for a wide range of models, technical assistance resources, and training programs.

4. Explore creative interdisciplinary and interagency solutions. Look to other disciplines and other agencies that have a stake in the issue for fresh viewpoints and opportunities to pool resources.

Changing fiscal climate[9]

Two major trends are converging to threaten the fiscal underpinnings of health and medical services for children with special health care needs. These are the block granting of Medicaid and the ongoing consolidation in evolving health provider-payer markets.

In the public arena, the pressures of a cap on the federal contribution to Medicaid growth and increased state discretion in program attributes with block granting of Medicaid will result in intense competition for health care funds. Compared to other contenders for the same dollars, children with needs for invasive health care procedures are a low incidence population. The loss of federal guarantees, protections, and quality standards, as well as caps on services, would be severe blows to these children and their families.

In the private sector, pressures to contain escalating health and medical costs have fostered rapid development of cost-effective payer systems, with managed care overtaking traditional indemnity insurance. Under the new systems of managed care, payers shift the risks associated with cost of services so that it is shared with providers. In the effort to reduce administrative overhead, they also shift most responsibility for monitoring provider quality, which is assumed assured by licensing, accrediting, and regulatory bodies.

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[9] The contributions of John Nackashi, MD, Phd, University of Florida at Gainesville, and Jim Carlisle, The Children's Hospital, Denver, over all three years of the Policy and Project were essential to comments and recommendations pertaining to the fiscal environment.

As the most cost-effective payer systems attract more covered lives through lower premiums, the payer market consolidates. Provider systems respond by realigning into integrated delivery systems that permit payers to contract with a single entity for a full array of services (hospitalization to home care) and providers (primary care physicians, specialists, allied health care providers, and so on). Through reimbursement mechanisms such as capitation (flat fee reimbursement per enrollee regardless of service utilization), the interaction of the resulting payer and provider systems creates strong financial motivation for gatekeeping (particularly reducing access to specialists) and limiting service utilization. Thus, three critical factors supporting the care of children with chronic illnesses and disabilities are threatened under these emerging systems--quality of care, access to specialists, and high service utilization.

The appeal of cost-effective payer-provider systems is encroaching from the private sector into the public arena. Twenty states have accomplished or are in the process of shifting Medicaid to managed care (Carlisle, 1996). Children who are medically fragile or technology-dependent require a complex web of medical, health and other supportive services. These individualized webs result from the painstaking parent-provider negotiation of complex regulations for Medicaid reimbursement. The shift to managed care for these children is a perilous one in terms of quality of, access to, and availability of needed services. Nor are these complex and costly enrollees desirable to managed care administrators.

Strategies

1. Establish relationships with the policy makers who will shape and administer state block grant Medicaid programs. Enlist their interests in representing the cause of these children to ensure the fair treatment in the changing health care landscape.
2. Maintain relationships with policy makers even after initial policies are determined--they will be reviewed and altered. If children with special needs are a continuous presence, they are less likely to be suffer disproportionate service cuts.
3. Advocate especially for retaining Medicaid eligibility for children below the poverty line and for maintenance of a developmentally-appropriate level of services so long as medically justified.
4. Become and remain knowledgeable about the philosophies, structures, and consequences of the health care payer-provider systems and educate policy makers and consumers as to the consequences of their choices.
5. Be aware of the ripple effects of changes in policy in one area upon related areas. Human service systems are also ecological systems. The withdrawal of services in one arena will be manifested in other arenas where the unmet needs emerge.
6. Initiate organization, or join with other child advocacy groups, to ensure that the special needs are met of children with chronic conditions and disabilities who require invasive procedures.

Unresolved Issues

As with all federal laws of its type, IDEA must undergo periodic reauthorization. This required review of the current language, purpose, and funding of an act often results in "opening up" the act to expansion or constriction of the scope, purpose and funding. Political climates and agendas may shape the resulting version upon reauthorization, as well as the funding.

The debate between what constitutes "medical" as opposed to "health" or "related" services also continues. Court decisions provide some guidance as to how the courts in a particular geographic area have interpreted the language of IDEA regarding these distinctions. There has not been a United States Supreme Court decision since the *Tatro* case (*Irving Independent School District v. Tatro*, 104 S.Ct. 3371, U.S. Sup. Ct. 1984; Rapport, 1996) that addresses the difference between medical and health services. The numbers of children requiring invasive procedures and the complexity of those procedures have increased dramatically since *Tatro* was decided in 1984. Cases decided by the lower federal circuit courts since Tatro differ considerably on the issue of where a health service ends and a medical service begins. Because of the change in legislation and the court opinions interpreting IDEA, it is essential that persons responsible for developing policy and practice for implementation of IDEA for children who require invasive procedures have a current and complete understanding of the legal context within which the policies and practices are to be developed.

Strategies

1. Develop methods and resources for keeping current with changes on the federal laws impacting children with special health care needs.
2. Develop methods for keeping current with court decisions affecting the delivery of special education services.

Engineering Systems Change

The starting point to foster inclusion for children with special health care needs is development of a vision for the children that is committed to their achievement of their maximal potential. Policy design and implementation should then flow from this vision. However, policy design and implementation are political processes, processes of influence. The skills of the change agent are essential to intervene in the process and influence design and implementation on behalf of children with invasive health care needs.

Strategies[10]

1. Identify the goal (long term) and objectives (shorter term) to achieved.
2. Assess the field. Identify the players and determine why they are interested. Try to understanding conflicting points of view and search for shared interests.
3. Establish coalitions. Identify sources of support, particularly those who have power and influence in the arenas to be impacted.

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[10] Special thanks to Linda Siderius, JD, First Assistant Attorney General of the State of Colorado, who presented to the conferences in 1995 and 1996, and Daniel O'Neal, Director of Government Affairs, American Nurses' Association, who presented in 1995, whose remarks were especially useful in defining change agent strategies.

4. Engage all of the concerned parties. Dissenting points of view must be addressed ultimately. Sooner is better.

5. Redefine the issues, if necessary, to achieve consensus on the goals. Work out disagreements before initiating the legislative process.

6. Explore the full range of solutions. Assess their desirability, viability, and comparative costs (emotional, psychological, social, and only economic).

7. Recognize that resistance to solutions may sometimes cloak apprehension or fear, and that they are best combatted with knowledge and support.

8. Assign priorities to solutions. Which will be pursued?

9. Define the framework for accomplishing the task. At what level must action be taken? What are the assignments? What is the timeframe for deadlines? Are there critical pathways to be addressed?

10. When meeting with legislators and others whom you are trying to enlist in your cause, make the meetings objective-driven:

- prepare for the meeting and have precise agenda items;
- arrive and depart promptly;
- present your position succinctly, with minimal jargon;
- employ anecdotes to illustrate points (they personalize issues and are easier to relate to and remember than statistics);
- define your base of support (broad-based multi-agency, multidiscipline, consumer-backed endeavors demand more attention than single entity efforts);

- reciprocate support offered to your cause;
- provide a brief, tangible summary of the main points; and,
- follow-up quickly with a thank you reiterating your position and providing requested information to establish yourself as a reliable source.

11. Reassess and evaluate the process and its progress periodically. Although there is a sequential nature to many of the strategies noted above, they do not constitute a recipe in which the steps can be completed and checked off. Accomplishment of any complicated agenda for change will require revisiting the definitions of goals, the slate of players, and the set of methods.

Conclusions

The complexity of issues facing those who seek to develop policy and practice for the implementation of IDEA for children with special needs who require invasive health care procedures is not to be underestimated. The requirements of the law at the federal and state levels and their interaction, transformations of the funding and reimbursement systems, the need to construe service delivery systems differently, ignorance of existing resources, the declining access of on-site nursing support, the increasing complexity of the children's conditions, and the anticipated reauthorization of IDEA must all be appreciated and addressed if the children's needs for health care and inclusion are to be reconciled.

An additional complication emerges in consideration of child care settings. Whereas education is an accepted function in the public domain, supported by tax dollars, and subject to much public regulation, child care is regarded, funded, and regulated far differently. A recent national study (Cost, Quality, & Child Outcomes Study Team, 1995) revealed the distressing variability in child care quality regardless of cost, with lowest quality for our youngest children. If it has proven so difficult to inform school districts of the legal and safety issues in serving children who need invasive procedures, how will the myriad independent child care facilities be alerted and their policies and practices brought in line with safe and legal standards within each state? Child care is a system financed in the main by parent dollars, yet consumers show little discrimination between high and low quality child care services in how they wield their economic leverage (Cost, Quality, & Child Outcomes Study Team, 1995). Furthermore, regulation and enforcement of guidelines varies widely from state to state. Thus, a concerted consumer education campaign is clearly warranted and may be the most feasible answer.

Education of consumers is also essential to alert them to the compromises that are being made to achieve cost efficiencies in health care coverage. Decreased access, availability and quality of services are often the price of lower premiums and a smaller government share. Children with chronic illnesses and disabilities may feel the losses most acutely.

Nor will the systems that serve these children's other needs be spared. The child with inadequate medical and health support will still present for admission to child care agencies, preschools, and elementary schools. Anticipated changes in health care will be felt in eduction, child care, and other human service arenas. Service providers in all of these fields must be made aware.

The extent of ignorance of state practice acts, even within the relevant disciplines, was among the most significant revelations during the three year project. Schools of Nursing and Medicine must instill in their graduates an appreciation for the importance of their state practice acts and the regulations promulgated from the acts. Graduates must be made aware of the importance of remaining current with changes in those acts and of advocating for needed amendments to protect their professional integrity and the welfare of those whom they serve. Schools of Education (including regular and special education and early intervention programs) must also take responsibility for preparing their graduates to address the educational, developmental, and health needs of an increasingly complex child population. They must also be made aware of the limitations imposed upon them by practice acts of regulated professions. Indeed, the call for interdisciplinary service models dictates curriculum revisions in professional and graduate schools to prepare their graduates to function collaboratively with colleagues in other disciplines (Larson, 1995).

Finally, a dimension that threads through every facet of this multi-faceted challenge is that of ethics. An ethical-moral framework is fundamental to guide decision-making in the midst of so many complicated issues. Policy makers, administrators, providers and parents will be confronted with difficult questions repeatedly in their efforts to implement IDEA for children who need invasive care. Many of the decisions will distill to a choice between what is convenient and what is right. Amid all the complexities there is one simple maxim: all children should have the opportunity to participate in life, not merely observe.

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APPENDICES

A National Survey of Nurse Practice Acts

Policy and Practice Resource Table

A National Survey of Nurse Practice Acts

Marjorie Long, J.D., Legal Consultant

Nurse Practice Acts are intended to protect the public. They are passed by the state legislature. The Board of Nursing promulgates rules and regulations to enforce the Act.

In most states permitting delegation, nursing tasks may be delegated either to specifically licensed and trained or only specifically trained individuals. In decisions to delegate the RN's license is on the line. The RN retains all responsibility for judgment -- it cannot be delegated.

The following is a synopsis of the review of delegation in the states completed in June, 1996.

Revised June 7, 1996

(This survey does not reflect legislation changes or amendments that may have occurred during the 1996 legislative session.)

Alabama: Teaching only, no delegation or supervision.

Alaska: "Allows for supervision, delegation, and evaluation of nursing practice to unlicensed assistive personnel (UAP's)." Outlines those aspects of nursing that may not be delegated.

Arizona: Delegation and supervision to auxiliary workers within the scope of their practice, e.g. nurse aides. Prescriptive authority for medications. Otherwise, only supervision, evaluation and teaching permitted, no delegation to unlicensed personnel.

Arkansas: Supervision and teaching of "other personnel." Delegation of certain nursing

California: School nurse may supervise "qualified, designated" school personnel to give physical care to student. Care must be under school nurse. Delegation specifically permitted under "Standards of Competent Performance."

Colorado: Delegation and supervision to unlicensed personnel permitted. Prescription authority granted to advance practice nurses by 1995 amendment.

Connecticut: Has defined scope of allowed delegable activities by nursing specialty. Prescription authority granted to advanced practice nurses.

District of Columbia: No information received.

Delaware: Permits delegation, supervision, and teaching.

Florida: Delegation is not in the statute but may exist in regulations. Teaching and supervision only allowed by statute as of October, 1994.

Georgia: "May teach and supervise." The term "delegation" is not included in broad practice standard to delegate and supervise under appropriate conditions. Teaching and supervision but no mention of delegation.

*Hawaii: M*ay teach, supervise, and delegate portions of nursing practice, but if any are improperly performed, the nurse is subject to "professional misconduct." Advanced practice nurses have prescriptive authority.

Idaho: Position Statement on Role and Responsibility of School Nurse allows delegation and teaching if there is no conflict within the practice act. Act does not specifically permit delegation.

Illinois: Supervision and teaching, but no delegation.

Iowa: Statute now permits "teaching, administering, delegating and evaluating nursing practice;" as well as delegating tasks "which assist in the nursing, medical or dental regime."

Indiana: "Position Statement" and Act allow for teaching and supervision, but no delegation.

Kansas: All delegated nursing procedures must be supervised, with the degree of supervision determined by an assessment of appropriate factors set forth in the statute.

Kentucky: Regulations permit delegation. Supervision, delegation, and teaching in statutory definition section.

Louisiana: Permits delegation of "nursing interventions to qualified nursing personnel in accordance with criteria established by the board [of nursing].

Maine: Delegation to LPNs and nursing assistants. Supervision and teaching of "nursing personnel permitted.

Maryland: Supervision and delegation of nursing practice permitted. Much legislative debate over issue of "forced" delegation in 1995 legislative session. (63,000 licensed nurses in state.) Statute amended in 1995 session to protect delegator nurse's judgment. Delegating nurse must be "readily available when delegating task to unlicensed individual.

Massachusetts: Teaching, delegation, and supervision (of unlicensed personnel) are permitted. Board of Nursing has issued a Position Statement specifically describing the practice of school nursing and issues of delegation.

Michigan: Permits delegation, teaching, and supervision by registered nurses, provided certain criteria are met, as outlined in regulations.

Minnesota: May be delegated "to other nursing personnel. (Broadly defined).

Mississippi: Delegation allowed within professional judgment of nurse. Teaching, delegation, and supervision in statutory definition.

Missouri: Teaching and supervision of unlicensed individuals, but no delegation of nursing tasks to unlicensed personnel. State has a Special Health Care Procedures Manual for provision of health services in a school setting.

Montana: Teaching, supervision, and delegation are permitted. Nurse is accountable to the consumer.

Nebraska: Permits delegation, teaching; supervision implied; delegated or assigned interventions must not conflict with the Act.

Nevada: Teaching, supervision and delegation are permitted, but delegation only to other nurses; can supervise other personnel if they are "qualified.

New Hampshire: Teaching, but not delegation.

New Jersey: No delegation or supervision and teaching of unlicensed persons within the statute.

New Mexico: By declaratory ruling: May delegate to non-licensed person who is prepared by education and experience to recognize and handle complications that may arise. Statute itself permits teaching and supervision. Practice of nursing definition includes delegation of nursing interventions that may safely be performed by others and are not in conflict with the NPA.

New York: No delegation or supervision.

North Carolina: May delegate to unlicensed person if six criteria are met (administrative rule). Includes "personal care" in a school setting. Supervision and teaching only contained in Act itself.

North Dakota: Teaching, supervision, and delegation of health and nursing practices are permitted.

Ohio: Regulations limit circumstances and tasks for delegation. Separate regulations apply to MR/DD institutions.

Oklahoma: Delegation, supervision, and teaching allowed.

Oregon: Board of Nursing prescribes "standards for the delegation of special tasks of patient care to nursing assistants and for the supervision of nursing assistants. Civil penalties imposed upon any institution using an untrained nursing assistant for more than 8 weeks. Certification of such persons is now required.

Pennsylvania: Health teaching permitted. No mention of delegation or supervision in Act itself.

Rhode Island: Teaching, but no delegation or supervision.

South Carolina: Teaching, supervision, and delegation of nursing practice are permitted.

South Dakota: Scope of practice permits teaching, delegation, and supervision.

Tennessee: Allows "managing, supervising and teaching of others" but does not permit delegation.

Texas: Regulations permit delegation and supervision with RN remaining "accountable. Texas Education Code gives immunity to school personnel administering medications.

Utah: Limited delegation in accordance with guidelines from Practice Issues Committee regarding child with Special Health Care Needs in School Setting. Teaching, delegation, and supervision are permitted by Act. Prescriptive authority for Advanced Practice RNs only and then only upon written consultation and referral plan, as of May, 1995.

Vermont: Delegation and supervision are permitted.

Virgin Islands: Permits only supervision and teaching.

Virginia: According to regulations, nurse may supervise and teach, but no delegation permitted.

Washington: Delegation, supervision, and teaching are permitted. Regulations contain specific protocol for delegation in community residential programs, which requires that nurse have patient's permission/informed consent to do so.

West Virginia: Supervision and teaching are allowed, but not delegation.

Wisconsin: Delegation and supervision allowed. Permits delegation of Nursing Act tasks to LPN or "less-skilled assistant.

Wyoming: Teaching, supervision, and delegation are permitted by statute. Advanced practice nurses have prescriptive authority by statute; scope defined by regulation.

POLICY AND PRACTICE RESOURCE TABLE

The following publications are available through:

National Maternal & Child Health Clearinghouse
8201 Greensboro Drive #600
McLean, VA 22101
(703) 821-8955

A Reader's Guide for Parents of Children with Mental, Physical or Emotional Disabilities

MCH Related Federal Programs: Legal Handbooks for Programs Planners (SSI Income for Disabled Children)

Family/Professional Collaboration for Families with Children with Special Health Needs and Their Families

Getting a Head Start on HIV

Developing a Community-based System for Children with Special Health Care Needs and Their Families: An Overview

Project Spoon: Special Program of Oral Nutrition for Children with Special Needs

Legal Issues in Pediatric HIV Practice: A Handbook for Health Care Providers

Children with Special Needs: A Resource Guide

Surgeon General's Report: Children with Special Health Care Needs

Family-centered Health Care for Medically Fragile Children

Parameters for Evaluation and Treatment of Patients with Cleft Lip/Palate Other Craniofacial Anomalies

Circles of Care and Understanding: Support for Fathers of Children with Special Needs

A National Goal: Building Service Delivery Systems for Children with Special Health Care Needs and Their Families

The Open Door: Parent Participation in State Policymaking about Children with Special Health Care Needs
National Health and Safety Performance Standards: Guidelines for Out-of-home Child Care Programs

Families on the Move

The following publications are available through:

Learner Managed Designs PO Box 3067
Lawrence, KS 66046
(913) 842-9088

Home Gastrostomy Care for Infants and Young Children (plus student booklet)

Home Tracheostomy Care for Infants and Young Children (plus student booklet)
Clean Intermittent Catheterization (plus student booklet)

Positioning for Infants and Young Children with Motor Problems (plus student booklet)

Communication with Preverbal Infants and Young Children (plus student booklet)

Feeding Infants and Young Children with Special Needs (plus student booklet)

Home Oxygen for Infants and Young Children

Infection Control in Child Care Settings

Handbook for the Care of Infants and Toddlers with Disabilities and Chronic Conditions

The following publications are available through:

Project School Care
Children's Hospital
300 Longwood Ave
Gardner 610
Boston, NA 02115
(617) 735-6714

Children Assisted by Medical Technology in Educational Settings: Guidelines for Care

Children Assisted by Medical Technology in Educational Settings: Resources for Training

The following publications are available through:

The Legal Center
455 Sherman Street #130
Denver, CO 80203
(800) 332-6356

The Future of Children with Disabilities is in Your Hands: Handbook of Rights to Special Education in Colorado

The Future Hands: Supplement to the Handbook of Rights to Special Education in Colorado: A Guide for Parents

First Steps to Discovery

Other materials from various sources:

AAUAP 1994 Resource Guide
AAUAP
8630 Fenton St., #410
Silver Spring, MD 20910
(301) 588-8252

National Nursing Standards of Nursing Practice for Early Intervention Services
Division of Parent-Child Nursing
College of Nursing
Univ. of Kentucky Chandler Medical Center
Lexington, KY 40536-2322

The Medically Fragile Child in the School Setting (item #451)
American Federation of Teachers
555 New Jersey Ave., N.W.
Washington, DC 20001

Administrator's Policy Handbook for Preschool Mainstreaming
Brookline Books P.O. Box 1046
Cambridge, MA 02238-1046

Managing the School Age Child with a Chronic Health Condition
Sunrise River Press
11481 Kost Dam Road
North Branch, MN 55056
(800) 551-4754

Management of Students with Health Impairments in the School Setting
Illinois State Board of Education
100 North First Street
Springfield, IL 62777-0001

Caregiver Education Guide for Children with Developmental Disabilities
Aspen Publishers, Inc.
200 Orchard Ridge Drive, #200
Gaithersburg, MD 20878
(800) 638-8437

RESOURCES AND REFERENCES

Procedure Guidelines for Health Care of Special Needs Students in the School Setting. Colorado Department of Education and Colorado Department of Public Health and Environment; 1988. (This manual is being revised and expected to be available by October 1994.)

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Standards of School Nursing Practice. American Nurses Association; 1983.

An Evaluation Guide for School Nursing Practice: Designed for Self and Peer Review. National Association of School Nurses; 1985.

Evaluating School Nursing Practice: A Guide for Administrators. American School Health Association; 1987.

NOTE: The three above publications are a series jointly developed by five nursing organizations and available from American School Health Association.

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Guidelines for a Model School Nursing Service Program. National Association of School Nurses; 1990

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Final Progress Report

Accomplishments to Date:

All of the original objectives planned for the 36- month period August 1,1993 - September 30,1996 have been accomplished. This section of the report describes these accomplishments.

GOAL

This project will provide information to state and local communities about the development of the appropriate policy, practice, and training opportunities needed to support inclusion of young children with special health care needs requiring invasive procedures (Individuals with Disabilities Education Act, IDEA). Specific information areas to be addressed are those of awareness, liability, and the need for training and dissemination.

PROJECT OBJECTIVES AND ACCOMPLISHMENTS

Objective 1 **Set forth appropriate laws, regulations, and standards which provide for safe delegation of nursing tasks to non-health professional.**

Method 1.1 Convene interdisciplinary Steering Committee inclusive of representatives of Special Health Care Task Force which worked to change the Colorado Nurse Act to include a delegatory clause.

Planned Activities - Years 01 and 01 and 03 - Completed

Ongoing consultation with the interdisciplinary education/health advisory group(Steering Committee) was conducted annually (Continuation Applications Yr. 2 & 3) via teleconference regarding: dissemination of the proceedings of the first two national conferences; the new developments in the policy and positions of the national organizations and agencies; updating of the reauthorization of IDEA and the implications for special education, and the program planning for each of Year 01, Year 02 and Year 03 national conferences. (SeeAppendix A).

Method 1.2 : Conduct national needs assessment.

Method 1.2.1 - 1.2.2 Analyze and summarize state review and needs assessment.

Planned Activities - Years 01 -03 Completed

In each on the three years of the Policy & Practice Grant, a survey was conducted to determine whether delegation of nursing tasks to unlicensed assistive personnel was permitted under each of the fifty-one state nurse practice acts (the statute), including Washington D.C. This survey was based upon the statute, as provided by the board of nursing in each state. The survey was published in the conference materials provided to each attendee in addition to a presentation on the topic by a licensed attorney who had analyzed each of the acts. Although there was a slight increase in the actual number of states that permitted delegation of nursing tasks to unlicensed personnel (27 in 1994 to 29 in 1996), the change could not be classified as a trend.

More significant was the change in the number of states that did not permit delegation of any sort (21 in 1994 compared to 13 in 1996). The net change in this category occurred primarily because a significant number of states moved from permitting no delegation whatsoever in 1994 to a specific class of licensed medical personnel. These people were variously described as: " nursing assistants", nurse aides", " qualified personnel", "licensed practical nurses", and similar terms. Some of these categories require licensing while others require only specific training or certification. In some cases the state nurse practice act was amended, in others the regulations promulgated under the act were modified to permit this limited delegation.

A few states have developed guidelines for delivery of health care in specific settings such as public schools and public institutions for persons with developmental disabilities. These guidelines may contain protocols for specific nursing tasks and the criteria to be used for delegation of each identified task.

Overall, it appears that states have become slightly more responsive to the special needs of children who require the performance of invasive procedures in order to be in an integrated setting such as a public school or child care program. While awareness of these needs and development of policies and practices to meet these needs was the primary focus of the grant, it is all too apparent that many people in administration, education, legislative bodies, and medical service delivery professions lack a basic understanding of the parameters imposed upon medical service delivery systems by their respective state professional acts such as nursing and medicine. Much education remains to be done.(See Appendix B).

Each year's data from the needs assessment was analyzed and made available to keep schools of early childhood education and early childhood special education updated on the critical issue of delegation of health care procedures.

Methods 1.2.3 - 1.2.6: Consult with Colorado State Board of Nursing, national nursing consultants, conduct review with interdisciplinary steering committee, and develop proceed framework to meet mandates of IDEA in each state

Planned Activities - Years 01 - 03 Completed

The advisory group's review of the Colorado Nurse Practice Act delegatory clause, regulations, and other position papers and documents resulted in the identification of a proposed draft of a framework through utilization of : a Model Nurse Practice Act and regulations; Standards of Nursing Practice; Model Paraprofessional Orientation and Training Plans, and Model Student Health Plans. (Continuation Application Year 03).

The review of proposed frameworks, including consultation from the National Council of State Boards of Nursing and the identification of safe, legal means to support services to children with special health care needs in the least restrictive environment in the education setting, took place in advisory group meetings, teleconferences, and the three national conferences conducted by the project in Year 02 on August 6 and 7 , 1994; in Year 02 on June 16 - 17 , 1995 (Continuation Application Year 03), and in Year 03 on June 14 and 15 , 1996 (See Appendix C).

Action plans were designed by a sample of the national conference attendees (Year 01 &02) for implementation in the home settings (Continuation Application Year 03). Planned post-conference evaluation which included the six-month follow-ups and subsequent annual assessment of the effectiveness of the action plans occurred following the national conferences held in 1994 and 1995 (Appendix D).

Objective 2: **Provide models of mechanisms to prepare personnel who are in positions to impact the implementation of IDEA to develop awareness and understanding of the complexity of the invasive procedures and how to administer them within the law. (Conduct Seminar.).**

Change in the Objective

A two day national conference (seminar) was held in the Denver area rather than in the Boulder conference center in Years 01, 02, and 03. This was done on the advice of the advisory group. The Denver location was chosen for its convenience to transportation .

Method 2.1: Review the existing curriculum/content on invasive procedures for necessary revisions and additions which are appropriate to present.

Each lesson on invasive procedures has undergone review for content validity, teaching strategies and interdisciplinary focus. Each national conference program has included review and familiarization with the invasive procedures and orientation to available training opportunities and supplemental learning resources and materials available in Colorado and nationally (See Appendix D).

Method 2.1.1 and 2.1.2: Review literature and develop program.

Planned activities - Years 01 --- 03 completed .

The lessons have been assessed on a continuing basis throughout the grant period by experts in their respective content fields and by national consultants, including Dr. Susan Sandall and Dr. Niclolas Anastaniow, on content, teaching strategies, and implications for early childhood education. Consultation has taken place with the producers of the supplementary training video/manual packages regarding invasive procedures that can be advertised to all early childhood special education programs nationwide.

Method 2.2 Review Colorado experience

Method 2.2.1 - 2.2.4: Develop seminar/revise content per expert review.

Planned activities - Years 01 --- 03 completed.

Each national conference has had the benefit of the ongoing assistance of the project's advisory group. Organization and content of each conference has been planned in cooperation with the advisory members; expert review has been sought from all the members. The programs developed for each year's conference (Continuation Application Year 03; See Appendix E) included the participation of members of the Colorado Special Interdisciplinary Education/Health Care Task Force.

In addition the national advisors, as well as the national and Colorado educators, paraprofessionals, nurses, parents, and young children who have experienced inclusion made possible by the development of policy and practice to implement IDEA related to invasive procedures were included in the planning of each of the three annual conferences. A national perspective has been maintained by the advisory group and project staff's ongoing review of the state-by-state status of laws that impact the practice of health care providers.

Included in the planning were the those activities impacted by the current Congressional activity regarding reauthorization of IDEA and the impact of the changing climate of the health care industry as it relates to care of children with special health care needs in schools and out of home child care. Monitoring by national advisors of nurse practice acts, developing case law, and national legislation related to reauthorization of IDEA and its impact on early childhood special education occurred throughout each of Year 01,02, and 03.

The dates of the first national conference,August 6-7,1994, were selected to avoid conflicting commitments for educators and administrators. The time required to complete the initial needs assessment, convene the advisory group, and plan and publicize the first conference necessitated scheduling it at the very beginning of Project Year 02. An extension was approved by the U.S. Department of Education of carry-forward funding because of the timing of the funding award for this grant. Timing and scheduling of subsequent conferences allowed for them to proceed within the appropriate year's funding time frame.

National Conferences

	Year 01 Conference	Year 02 Conference	Year 03 Conference
Location	Denver	Denver	Denver
Date	August 6-7,1994	June 16-17,1995	June 14-15,1996
# Attendees	55	56	53
States Represented	16	20	17

Issue Categories of the Three National Conferences

Characteristics of the children
- Disability and Cultural Diversity
- Status of Care in child care and schools (including procedures required)
- Parent Advocate perspectives

IDEA
- Reauthorization of IDEA (Changes for CSHCN)

Nurse Practice Acts
- National surveys
- Delegated Medical Functions and the Nurse Practice Act
- Role of State Boards of Nursing
- Role of Administrative Agencies

Safe and Legal Delegation

- Delegation as a managerial concept
- Risks and Consequences of Delegation of Invasive Procedures
- Training for Safe and Legal Delegation
- Delegation by Other Disciplines

Inclusion

- Educators' perspective (national education initiatives and the classroom)
- Status of care in child care and schools

Professional Collaboration and Territoriality

- Interdisciplinary collaboration
- Scope of Delegation within Other Licensed Health Care Providers Practice Acts

Ethics

Systems Change

- Impact of National, State, and Local Political Processes (School District Policy)
- Risk Management
- Impacting Organizations
- Change Skills

Funding

- Evolving Health Care System
- Managed Care and Managed Care Organizations
- Impending Changes in SSI, MCH, Medicaid as a Block Grant, Other Related Federal Programs
- State and Local Funding Strategies

Training

- Technical Assistance Resources
- Models (train the trainer, consultation, DPS)

Method 2.3: Conduct three Policy and Practice Program information conferences

Methods 2.3.1 - 2.3.3: Announce conference and recruit participants; submit applications to advisory group review; conduct three conferences.

Planned Activities - Years 01 - 03, completed.

The conference programs for each of the three national conferences were mailed to members of national organizations and agencies, announced in national newsletters, and disseminated on Internet, NEC*TAS (National Early Childhood Technical Assistance System), Special Net. In addition to the Internet, national conference presentations and contact with state departments of Education and Public Health were other vehicles used in disseminating announcements of the national conferences. 2377 announcements and brochures were mailed for the Year 03 conference.

This mailing was representative of the mailings for the previous two conferences One hundred sixty four participants from 33 states were in attendance at the three national conferences conducted during the period of this grant.

These 33 states are represented by each of the six Regional Resource Centers (RRCS) located around the United States. The RRCs , authorized through P.L.102-119 (IDEA) were established regionally to support state education agencies in exercising leadership in improving special education services and services to children with special needs. Through utilization of the RRCs within their individual states, the participants from the national conferences have the ability to expand the availability of the information gained from the conference content (See Appendix F).

Methods 2.4 - 2.8: Conduct, evaluate, revise conference content plans.

Planned Activities - Years 01 -03 completed

Instruments for evaluation were developed and /or revised following each of the national conferences. These instruments included measures to address the level of confidence attained by participants in their ability to institute systems change for inclusion of young children with special health care needs related to invasive procedures, in their home settings. Overall participants rated the conferences positively and felt confident they would be able to initiate program change in their home states. (See Appendix G).

Objective 3: **Increase each state's awareness of the need to examine legal obligations and constraints; understanding of what the special health care needs are for infants and young children who present complex medical needs: and their recognition of the interagency cooperation needed to serve these children in mainstream settings.**

Methods 3.1 - 3.6: **Compile, disseminate, and publicize availability of the proceedings of Policy and Practice Program Conferences # 1, # 2, and # 3; including consultation with the National Early Childhood Technical Assistance System (NEC*TAS).**

Planned Activities - Years 01 - 03 Completed

The Advisory Committee, project staff and project director have reviewed numerous methods of dissemination of the proceedings and related information available through the national conferences conducted via this grant. These discussions have included information gathered as a result of meetings with: the educational services media personnel of the University of Colorado, the national consultants of the project, the advisory group member and consultant representing NEC*TAS, and representatives of the Denver FREE - NET, ERIC and NICHY. Following consultation with the project manager Dr. Martha Bokee, the project director developed a plan to announce the availability of the proceedings to all graduate and undergraduate programs of early childhood education and early childhood special education. Offering the proceedings at cost to other appropriate agencies and organizations was also explored. Investigation also pursued the possibility of utilization of the Internet and a Website for dissemination of the proceedings.

Proceedings of conferences #2 and #3 reflect the current status of the reauthorization of IDEA as well as other Federal legislation which may impact children with special health care needs. The proceedings also include resource guides and information on how to request and receive technical assistance from the Policy and Practice project staff, as well as consultants in each state from which inquiries have been received.

The proceedings from Year 02 and Year 03 also reflect the immense wealth of information and activity occurring across the county with regard to the implementation of IDEA and services for children with special health needs. Recipients in reading the Proceedings from Year 02 and Year 03 will by referring between each document be able to see the rapid changes which occurred in the brief period of one year. Dissemination of the proceedings of Year 02 and Year 03 is proceeding according to plan (See Appendix H).

LIST OF APPENDICES

A. Programs Brochures Years' 01, 02, 03

B. National Nurse Practice Acts Survey (revised June 1996)

C. Follow-up Evaluations

D. Resource Table Year 03

E. Conference program year 03

F. States in attendance by RRCs

G. Evaluations Year 02 & 03

H. Conference Proceedings Year 02 & 03

APPENDICE A

Programs Brochures Years' 01, 02, 03

Policy and Practice To Implement I.D.E.A.
University of Colorado Health Sciences Center
School of Nursing
4200 East Ninth Avenue, Box C287
Denver, Colorado 80262

BEST COPY AVAILABLE

CALL TO ACTION

MEETING THE CHALLENGE OF INCLUSION FOR YOUNG CHILDREN WITH SPECIAL HEALTH CARE NEEDS

hat is mandated under Federal and State Law?

hat are the Resources?

hat Training is Available?

Cherry Creek Inn
Denver, Colorado

Sponsored by the
University of Colorado Health Sciences Center
School of Nursing
with the support of the
U.S. Department of Education

To Implement I.D.E.A. Related to Special Health Care Needs (Invasive Procedures, such as Tracheostomy Care, Gastrostomy Feeding) of Young Children

You know what FAPE (free appropriate public education) and LRE (least restrictive environment) are, but do you know what invasive procedures are? (Is there really a connection?)

* Who in your program is trained to perform invasive proc dures? (Is it legal for them to perform those procedures?)

* Is your program in compliance with your state's Nurse Practice Act? (What is a Nurse Practice Act, anyway?)

* Can your program budget accommodate specialized healt care services to infants, toddlers, and preschoolers who hav special health care needs?

* Are you violating the integration/inclusion requirements of I.D.E.A. in your provision of special health care services?

* What resources are available to assist your program or agency in the provision of specialized health care services to young children?

* Could you be on the forefront of serving children who ar "technology dependent" or "medically fragile"?

* EDUCATORS
* EARLY CHILDHOOD SPECIAL EDUCATORS
* SCHOOL NURSES/NURSES
* PARENTS
* PEDIATRIC HEALTH CARE PROVIDERS
* ADMINISTRATORS/POLICY MAKERS
* PARAPROFESSIONALS
* PERSONNEL PREPARATION SPECIALISTS
* PHYSICAL/SPEECH/OCCUPATIONAL THERAPISTS
* STATE BOARD OF NURSING MEMBERS AND
* OTHERS SERVING CHILDREN WITH SPECIAL NEEDS

DEVELOPING POLICY AND PRACTICE TO IMPLEMENT I.D.E.A

SATURDAY, AUGUST 6

8:30 a.m. Welcoming Remarks

Bea Romer
First Lady, Colorado, and Chair,
First Impressions Council for Children

8:45 a.m. Introduction

Marilyn Krajicek, Ed.D., RN, FAAN
Project Director, Associate Professor,
UCHSC School of Nursing

9:00 a.m. Panel: Why We Are Here-Medical/Legal Issues

Travis' Story: Family and Education
Brian McNulty, Ph.D.
Assistant to the Commissioner,
Colorado Department of Education
MD Consultant
Children with Disabilities
Victoria Hertel, RN, MS
CO School Nurse Consultant
CO Dept. of Health, CO Dept. of Ed
Marjorie Long, JD, Esq., Denver, CO

10:30 a.m. Refreshment Break

10:45 a.m. Group Sessions (To be repeated at 2:45 pm)

A: Quality of Care: The Structure That Allows for Safe and Legal Delegation

Betty Presler, RN, Ph.D., U of KY, Com. on National Standards of
Nursing Practice, Early Intervention
Victoria Hertel, Colorado School Nurse Consultant
Patricia Motz, Ed.D., R.N., Consultant, Employee Health Services,
Denver Public Schools
Retha Fordyce, Pres., Denver Fed. Paraprofessionals

B: Issues in Special Education - Inclusion

David Stockford, President, National Association of State Directors
of Special Education
Fred Smokoski, Ed.D., Director, Special Education
Services Unit, Colorado Department of Education

C: Issues of Ethics, Advocacy, Funding

Kao Sunada, MD, Medical Consultant, Denver, CO
Marie Swigert, RN, MS, Director, Community Health
Services, Colorado Department of Health
Randy Chapman, The Legal Center, Denver, CO
Harriet Boone, Ph.D., Ethics, Univ. of NC, Chapel Hill

12:00 noon The Future of Health Care

The Hon. Patricia Schroeder
Luncheon Speaker

1:30 p.m. Systems Change: How to Influence Policy Making

Patricia Rowell, R.N., Ph.D., Senior Policy Fellow,
American Nurses' Association
David Stockford, President, NASDSE
Medical and Advocacy Role Spokespersons
Parents: Kit Hovey
Community Board Spokesperson

2:30 p.m. Refreshment Break
2:45 p.m. Group Sessions Repeated
4:00 p.m. Challenge for Tomorrow

SUNDAY, AUGUST 7

7:00 a.m Continental Breakfast
8:00 a.m. Challenges for the Future/Funding

Dissemination

What Will You Do in Your Communities? How Will You Work with Your State Boards of Education and Nursing? Training/Funding Resources: What Assistance Will You Need?

Jim Carlisle, Marketing Mgr., The Children's Hospital, Denver, CO
Jo Shackelford, Technical Assistance Coordinator,
Univ. of NC, Chapel Hill
National Early Childhood Technical Assistance System

9:00 a.m. Break

9:15 a.m. Creating Action Plans Discussions and Problem Solving

Conference Program Facilitators, Recorders

10:30 a.m. Summary

Evaluation of Conference
Ongoing Evaluation Plan
Technical Assistance Available and Charge

MOVE FORWARD WITH ACTION PLANS

Multimedia Exhibit of Training Programs and Materials
Saturday, August 6 - Sunday, August 7, 1994

Attendees will have the opportunity to view and evaluate training programs and media, available nationally, regarding invasive procedures.
Attendants will be available to answer questions during the Conference.

ENROLLMENT: Applicants are encouraged to develop state and community teams with the capacity and interest to facilitate action to develop individualized action plans including plans to examine and to set in place laws and regulations to achieve safe, legal delegation in their own states and communities. Registration is limited.

COST: The cost of registration for the two-day Policy and Practice Conference is $75.00 per person. Registration fees cover conference materials, refreshment breaks and lunch on Saturday. Each person attending will be responsible for the cost of travel, lodging, and per diem.

CONFERENCE SITE AND LODGING: The Cherry Creek Inn, 600 S. Colorado Blvd., Denver, CO 80222.,
Tel. 303-757-3341, FAX 303-756-6670,
Accommodations for conference participants and their guests are available at the special rate of $57.00 per room per night plus tax. The special rate is also available to conference participants for an extended stay either before or after the conference. When calling, please identify yourself as attending the Policy and Practice Conference; to ensure accommodations, reservations should be made by July 15, 1994.

SPECIAL AIR TRAVEL DISCOUNT: Conference attendees and families are eligible for discounts on domestic United Airlines and United Express. Fares quoted are 10% off unrestricted coach fares or 5% off lowest applicable fare and are available for travel between August 2-10, 1994. For a no obligation quote, call Wright Travel at 800-937-0997 or 303-799-0220, Monday through Friday, 7:30 am - 5:00 pm, Mountain Standard Time, or FAX 303-799-6625. Refer to Policy & Practice National Conference.

NAME ____________________
TITLE ____________________
ORGANIZATION ____________________
ADDRESS ____________________
____
WORK PHONE ____________________
HOME PHONE ____________________
FAX NUMBER ____________________

Marilyn J. Krajicek, EdD, RN, FAAN
University of Colorado Health Sciences Center
School of Nursing
4200 E. Ninth Avenue, C287
Denver, Colorado 80262
TEL. (303) 270-8734 FAX (303) 270-8660

BEST COPY AVAILABLE

CALL TO ACTION

SECOND NATIONAL CONFERENCE
Denver,Colorado
June 15, 16, 17, 1995

A CALL TO ACTION: DEVELOPING POLICY AND PRACTICE TO IMPLEMENT I.D.E.A. FOR INCLUSION OF YOUNG CHILDREN WITH SPECIAL HEALTH CARE NEEDS

- How are programs nationwide meeting the inclusion requirements of I.D.E.A. in the provision of specialized health care services, invasive procedures such as tracheostomy care and gastrostomy feeding, for young children?

- What resources are available to assist you and your program or agency in the provision of specialized health care services to young children?

- How are states working to assure the availability of appropriately trained non-licensed personnel to serve children who are "technology dependent" or "medically fragile"?

WHO SHOULD ATTEND?

- ADMINISTRATORS/POLICY MAKERS
- EARLY CHILDHOOD SPECIAL EDUCATORS
- EDUCATORS
- PARAPROFESSIONALS
- PARENTS
- PEDIATRIC HEALTH CARE PROVIDERS
- PERSONNEL PREPARATION SPECIALISTS
- PHYSICAL/SPEECH/OCCUPATIONAL THERAPISTS
- SCHOOL NURSES/NURSES
- STATE BOARD OF NURSING MEMBERS
- OTHERS SERVING CHILDREN WITH SPECIAL NEEDS

FOR FURTHER INFORMATION, PLEASE RETURN THE FORM PROVIDED ON THE REVERSE SIDE OF THIS ANNOUNCEMENT.

DEVELOPING POLICY AND PRACTICE TO IMPLEMENT I.D.E.A.
Second National Conference
Denver, Colorado
June 15 - 17, 1994

Sponsored by the University of Colorado Health Sciences Center School of Nursing, supported by the U.S. Department of Education, Personnel Preparation #H029K30189.

Issues to be addressed in meeting the challenge of inclusion for children with special health care needs will include:

Medical-Legal Issues

I.D.E.A. mandates that states provide early intervention services for infants and young children (birth to 5) with special health care needs in regular school, preschool and child care settings. Is your program in compliance with the inclusion requirements and with your state's Nurse Practice Act in the provision of special health care services?

Quality of Care

What structure allows for safe and legal delegation of special health care services to non-licensed personnel?

Funding Issues

How will your program budget accommodate services to infants, toddlers, and preschoolers who have special health care needs?

Systems Change

Considering the number of issues, how can interdisciplinary teams working with families and communities influence policy-making?

Program Design, Staffing, Training

How are programs nation-wide meeting the inclusion requirements of I.D.E.A. in the provision of special health care services? Who in your program is trained to perform invasive procedures? Is it legal for them to perform those procedures? What resources are available to assist your program in the provision of special health care services to young children?

Future Directions

What are the appropriate components of a model program of inclusion for young children with special health care needs?

TO RECEIVE INFORMATION, PLEASE FAX OR MAIL THIS FORM TO:

Marilyn J. Krajicek, EdD, RN, FAAN, Policy & Practice Project
UCHSC School of Nursing, 4200 E. Ninth Avenue, C287, Denver, Colorado 80262
TEL. (303) 270-8734 FAX (303) 270-8660

- -

NAME: ______________________________

TITLE: ______________________________

ORGANIZATION: ______________________________

ADDRESS: ______________________________

____

WORK PHONE: ______________ **FAX NUMBER:** ______________

Policy and Practice to Implement I.D.E.A.
University of Colorado Health Sciences Center
School of Nursing
4200 East Ninth Avenue, Box C287
Denver, Colorado 80262

CALL TO ACTION! THIRD NATIONAL CONFERENCE

DEVELOPING POLICY AND PRACTICE FOR INCLUSION OF YOUNG CHILDREN WITH SPECIAL HEALTH NEEDS
(Invasive Health Procedures)

What's happening to Inclusion for Young Children with Special Health Care Needs?

EXPLORE THE ISSUES IN A NATIONAL MULTIDISCIPLINARY CONFERENCE

Sponsored by the
University of Colorado Health Sciences Center
School of Nursing
with the support of the
U.S. Department of Education
Project HO29K30189

Denver, Colorado
June 14 - 15, 1996

CALL TO ACTION

MEETING THE CHALLENGE OF INCLUSION FOR YOUNG CHILDREN WITH SPECIAL HEALTH CARE NEEDS

* Is your program meeting the inclusion requirements of the law in provision of special health care services for young children?

* What resources are available to assist your and your program in provision of special health care services to young children?

* How are states working to assure availability of appropriately trained non-licensed personnel to serve young children with special health care needs?

WHO SHOULD ATTEND?

*** EDUCATORS**
*** PARENTS**
*** EARLY CHILDHOOD SPECIAL EDUCATORS**
*** SCHOOL NURSES/NURSES**
*** PEDIATRIC HEALTH CARE PROVIDERS**
*** ADMINISTRATORS/POLICY MAKERS**
*** PARAPROFESSIONALS**
*** PERSONNEL PREPARATION SPECIALISTS**
*** PHYSICAL/SPEECH/OCCUPATIONAL THERAPISTS**
*** STATE BOARD OF NURSING MEMBERS AND**
*** OTHERS SERVING CHILDREN WITH SPECIAL NEEDS**

REGISTER NOW!
ENROLLMENT IS LIMITED!

THIRD NATIONAL CONFERENCE
Denver, Colorado
June 14-15, 1996

DEVELOPING POLICY AND PRACTICE TO IMPLEMENT I.D.E.A. FOR INCLUSION OF YOUNG CHILDREN WITH SPECIAL HEALTH CARE NEEDS

(Invasive Procedures, such as Tracheostomy Care, Gastrostomy Feeding)

THE CONFERENCE:

A Networking Seminar for Interdisciplinary Professionals, Parents, and Paraprofessionals Working with Young Children with Special Health Care Needs to Explore the Issues:

- **Is your program in compliance with your state's Nurse Practice Act?**
- **Who in your program is trained to perform invasive procedures?**
- **Is it legal?**
- **Can your program budget accommodate special health care services to infants, toddlers, and preschoolers?**
- **Can you be in the forefront of serving these children and their families?**

ENROLLMENT:

Applicants are encouraged to develop state and community teams with the capacity and interest to facilitate action to achieve safe, legal delegation in their own states and communities. **Registration is limited.**

COST:

The cost of registration for the two-day Policy and Practice Conference is $125.00 per person. Registration fees cover conference materials, refreshment breaks and lunches. Each person attending will be responsible for their own travel, lodging, and per diem.

CONFERENCE SITE AND LODGING:

The Warwick Hotel, 1776 Grant Street, Denver, CO 80203 Tel. 1-800-525-2888; Tel. 303-861-2000; FAX 303-832-0320. Accommodations for conference participants and their guests are available at the rate of $77.00/single, $87.00/double per night plus tax. Please identify yourself as attending the Policy and Practice Conference; to ensure accommodations, reservations should be made by June 1, 1996.

REGISTRATION:

NAME: ____________________

TITLE: ____________________

ORGANIZATION: ____________________

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ADDRESS: ____________________

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WORK PHONE: ____________________

HOME PHONE: ____________________

FAX NUMBER: ____________________

TO REGISTER, PLEASE CALL, FAX OR MAIL THIS FORM TO:

Marilyn J. Krajicek, EdD, RN, FAAN
University of Colorado Health Sciences Center
School of Nursing
4200 E. Ninth Avenue, C287
Denver, Colorado 80262
TEL. (303) 270-8734 FAX (303) 270-8660

APPENDICE B

National Nurse Practice Acts Survey
(revised June 1996)

Marjorie J. Long, J.D.
Nurse Practice Acts Survey
Revised June 7, 1996

STATE	RESPONSE
Alabama	Teaching only, no delegation or supervision.
Alaska	"Allows for supervision, delegation, and evaluation of nursing practice to unlicensed assistive personnel (UAP's)." Outlines those aspects of nursing that may not be delegated.
Arizona	Delegation and supervision to auxiliary workers within the scope of their practice, e.g. nurse aides. Prescriptive authority for medications. Otherwise, only supervision, evaluation and teaching permitted, no delegation to unlicensed personnel.
Arkansas	Supervision and teaching of "other personnel." Delegation of certain nursing practices to other personnel as set forth in regulations.
California	School nurse may supervise "qualified, designated" school personnel to give physical care to student. Care must be under school nurse. Delegation specifically permitted under "Standards of Competent Performance."
Colorado	Delegation and supervision to unlicensed personnel permitted. Prescription authority granted to advance practice nurses by 1995 amendment.
Connecticut	Has defined scope of allowed delegable activities by nursing specialty. Prescription authority granted to advanced practice nurses.
District of Columbia	No information received.
Delaware	Permits delegation, supervision, and teaching.

STATE	RESPONSE
Florida	Delegation is not in the statute but may exist in regulations. Teaching and supervision only allowed by statute as of October, 1994.
Georgia	"May teach and supervise." The term "delegation" is not included in broad practice standard to delegate and supervise under appropriate conditions. Teaching and supervision but no mention of delegation.
Hawaii	May teach, supervise, and delegate portions of nursing practice, but if any are improperly performed, the nurse is subject to "professional misconduct." Advanced practice nurses have prescriptive authority.
Idaho	Position Statement on Role and Responsibility of School Nurse allows delegation and teaching if there is no conflict within the practice act. Act does not specifically permit delegation.
Illinois	Supervision and teaching, but no delegation.
Indiana	Statute now permits "teaching, administering, delegating and evaluating nursing practice;" as well as delegating tasks "which assist in the nursing, medical or dental regime."
Iowa	"Position Statement" and Act allow for teaching and supervision, but no delegation.
Kansas	All delegated nursing procedures must be supervised, with the degree of supervision determined by an assessment of appropriate factors set forth in the statute.
Kentucky	Regulations permit delegation. Supervision, delegation, and teaching in statutory definition section.

STATE	RESPONSE
Louisiana	Permits delegation of "nursing interventions to qualified nursing personnel in accordance with criteria established by the board [of nursing]."
Maine	Delegation to LPNs and nursing assistants. Supervision and teaching of "nursing personnel" permitted.
Maryland	Supervision and delegation of nursing practice permitted. Much legislative debate over issue of "forced" delegation in 1995 legislative session. (63,000 licensed nurses in state.) Statute amended in 1995 session to protect delegator nurse's judgment. Delegating nurse must be "readily available when delegating task to unlicensed individual."
Massachusetts	Teaching, delegation, and supervision (of unlicensed personnel) are permitted. Board of Nursing has issued a Position Statement specifically describing the practice of school nursing and issues of delegation.
Michigan	Permits delegation, teaching, and supervision by registered nurses, provided certain criteria are met, as outlined in regulations.
Minnesota	May be delegated "to other nursing personnel." (Broadly defined).
Mississippi	Delegation allowed within professional judgment of nurse. Teaching, delegation, and supervision in statutory definition.
Missouri	Teaching and supervision of unlicensed individuals, but no delegation of nursing tasks to unlicensed personnel. State has a Special Health Care Procedures Manual for provision of health services in a school setting.
Montana	Teaching, supervision, and delegation are permitted. Nurse is accountable to the consumer.

STATE	RESPONSE
Nebraska	Permits delegation, teaching; supervision implied; delegated or assigned interventions must not conflict with the Act.
Nevada	Teaching, supervision and delegation are permitted, but delegation only to other nurses; can supervise other personnel if they are "qualified."
New Hampshire	Teaching, but not delegation.
New Jersey	No delegation or supervision and teaching of unlicensed persons within the statute.
New Mexico	By declaratory ruling: May delegate to non-licensed person who is prepared by education and experience to recognize and handle complications that may arise. Statute itself permits teaching and supervision. Practice of nursing definition includes delegation of nursing interventions that may safely be performed by others and are not in conflict with the NPA.
New York	No delegation or supervision.
North Carolina	May delegate to unlicensed person if six criteria are met (administrative rule). Includes "personal care" in a school setting. Supervision and teaching only contained in Act itself.
North Dakota	Teaching, supervision, and delegation of health and nursing practices are permitted.
Ohio	Regulations limit circumstances and tasks for delegation. Separate regulations apply to MR/DD institutions.
Oklahoma	Delegation, supervision, and teaching allowed.

STATE	RESPONSE
Oregon	Board of Nursing prescribes "standards for the delegation of special tasks of patient care to nursing assistants and for the supervision of nursing assistants." Civil penalties imposed upon any institution using an untrained nursing assistant for more than 8 weeks. Certification of such persons is now required.
Pennsylvania	Health teaching permitted. No mention of delegation or supervision in Act itself.
Rhode Island	Teaching, but no delegation or supervision.
South Carolina	Teaching, supervision, and delegation of nursing practice are permitted.
South Dakota	Scope of practice permits teaching, delegation, and supervision.
Tennessee	Allows "managing, supervising and teaching of others" but does not permit delegation.
Texas	Regulations permit delegation and supervision with RN remaining "accountable." Texas Education Code gives immunity to school personnel administering medications.
Utah	Limited delegation in accordance with guidelines from Practice Issues Committee regarding child with Special Health Care Needs in School Setting. Teaching, delegation, and supervision are permitted by Act. Prescriptive authority for Advanced Practice RNs only and then only upon written consultation and referral plan, as of May, 1995.
Vermont	Delegation and supervision are permitted.

STATE	RESPONSE
Virgin Islands	Permits only supervision and teaching.
Virginia	According to regulations, nurse may supervise and teach, but no delegation permitted.
Washington	Delegation, supervision, and teaching are permitted. Regulations contain specific protocol for delegation in community residential programs, which requires that nurse have patient's permission/informed consent to do so.
West Virginia	Supervision and teaching are allowed, but not delegation.
Wisconsin	Delegation and supervision allowed. Permits delegation of Nursing Act tasks to LPN or "less-skilled assistant."
Wyoming	Teaching, supervision, and delegation are permitted by regulation. Advanced practice nurses have prescriptive authority by statute; scope defined by regulation.

Revised June, 1996

NATIONAL NURSE PRACTICE ACT SURVEY

Revised June, 1995

STATE	RESPONSE
Alabama	Teaching only, no delegation or supervision.
Alaska	"Allows for supervision, delegation, and evaluation of nursing practice."
Arizona	Delegation and supervision to auxiliary workers within the scope of their practice, e.g., nurse aides. Dispensing of medications by school personnel under study. Otherwise, only supervision and teaching permitted, no delegation to unlicensed personnel
Arkansas	Supervision and teaching of "other personnel."
California	School nurse may supervise "qualified, designated" school personnel to give physical care to student. Care must be under school nurse. Delegation specifically permitted under "Standards of Competent Performance."
Colorado	Delegation and supervision to unlicensed personnel permitted. Prescription authority granted to advance practice nurses by 1995 amendment.
Connecticut	Has defined scope of allowed delegable activities by nursing specialty. Prescription authority granted to advance practice nurses.
District of Columbia	No new information received.
Delaware	Permits delegation, supervision, and teaching.
Florida	Delegation and supervision are not in the statute but may exist in regulations. Teaching and supervision only allowed by statute as of October, 1994.
Georgia	"May teach and supervise." The term "delegation" is not included in broad practice standard to delegate and supervise under appropriate conditions. Teaching and supervision but no mention of delegation.
Hawaii	May teach, supervise, and delegate portions of nursing practice, but if any are improperly performed, the nurse is subject to "professional misconduct."
Idaho	Position Statement on Role and Responsibility of School Nurse allows delegation and teaching if there is no conflict within the practice act. Act does not specifically permit delegation
Illinois	Supervision and teaching, but no delegation.
Indiana	Statute now permits "teaching, administering, delegating and evaluating nursing practice;" as well as delegating tasks "which assist in the nursing, medical or dental regime."
Iowa	"Position Statement" and Act allow for teaching and supervision, but no delegation.

STATE	RESPONSE
Kansas	Delegation in school setting of specific tasks. Under review--problems may have arisen. Delegation of auxiliary patient care services" and administration of meds. by person who has completed meds. administration program.
Kentucky	Regulations permit delegation. Supervision, delegation, and teaching in statute definition.
Louisiana	Allows for instruction, supervision and delegation of "selected nursing functions approved by the Board."
Maine	Delegation to LPNs and nursing assistants. Teaching permitted.
Maryland	Supervision and delegation of nursing practice permitted. Much legislative debate over issue of "forced" delegation in 1995 legislative session. (63,000 licensed nurses in state.) Statute amended in 1995 session to protect delegator nurse's judgment.
Massachusetts	Teaching, delegation, and supervision (of unlicensed personnel) are permitted.
Michigan	Permits delegation, teaching, and supervision by registered nurses, provided certain criteria are met, as outlined in regulations.
Minnesota	May be delegated to nursing personnel (broadly defined).
Mississippi	Delegation allowed within professional judgment of nurse. Teaching, delegation, and supervision in definition.
Missouri	Teaching and supervision of unlicensed individuals, but no delegation of nursing tasks to unlicensed personnel. State has a Special Health Care Procedures Manual for provision of health services in a school setting.
Montana	Teaching, supervision, and delegation are permitted.
Nebraska	Permits delegation, teaching; supervision implied.
Nevada	Teaching, supervision, and delegation are permitted. Delegation only to other nurses, can supervise other personnel if they are "qualified."
New Hampshire	No new information received
New Jersey	No delegation or supervision and teaching of persons by statute.
New Mexico	By declaratory ruling: May delegate to non-licensed person who is prepared by education and experience to recognize and handle complications that may arise. Statute itself permits teaching and supervision, but does not mention delegation. Practice of nursing definition includes delegation of nursing interventions that may safely be performed by others and are not in conflict with the NPA.
New York	No delegation or supervision, but legislative amendment being sought.
North Carolina	May delegate to unlicensed person if six criteria are met (administrative rule). Includes "personal care" in a school setting. Supervision and teaching only contained in Act itself.

STATE	RESPONSE
North Dakota	Teaching, supervision, and delegation of health and nursing practices are permitted.
Ohio	May supervise and delegate nursing practice.
Oklahoma	Delegation, supervision, and teaching allowed.
Oregon	Declaratory ruling regarding unauthorized practice by school aides allowing CIC. Teaching and delegation permitted; supervision of "nursing assistants" allowed. "Interim" version, December, 1994, remains unchanged. Delegation permitted by regulation only in certain facilities, which do not include public schools.
Pennsylvania	Health teaching permitted. No mention of delegation or supervision in Act itself.
Rhode Island	Teaching, but no delegation or supervision.
South Carolina	Teaching, supervision, and delegation of nursing practice are permitted.
South Dakota	Scope of practice permits teaching, delegation, and supervision of "trained individual with the authority to perform a specific nursing task in a specific situation. However- aiding or abetting "an unlicensed or uncertified person to practice nursing" is grounds for revocation or suspension of nursing license.
Tennessee	Allows "managing, supervising and teaching of others" but no longer permits delegation.
Texas	May supervise and delegate. Texas Education Code gives immunity to school personnel administering medications.
Utah	Limited delegation in accordance with guidelines from Practice Issues Committee regarding child with Special Health Care Needs in School Setting. Teaching, delegation, and supervision are permitted by Act. Prescriptive authority for Advanced Practice R.N.'s only and then only upon written consultation and referral plan, as of May, 1994.
Vermont	Delegation and supervision are permitted.
Virginia	Nurse may supervise and teach, but no delegation permitted.
Washington	Delegation, supervision, and teaching are permitted.
West Virginia	Supervision and teaching are allowed, but not delegation.
Wisconsin	Delegation and supervision allowed. Under study by task force.
Wyoming	Teaching, supervision, and delegation are permitted.

APPENDICE C

Follow-up Evaluations

POLICY & PRACTICE TO IMPLEMENT IDEA RELATED TO INVASIVE HEALTH PROCEDURES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Follow-up Evaluations:

1994 One year extended follow-up and

1995 Six month Conference impact questionnaire & action plan progress report

July, 1996

prepared by
Geraldine Steinke, PhD
Project Consultant

The 1994 and 1995 Conferences on Developing Policy and Practice to Implement IDEA related to Invasive Health Procedures for Children with Special Health Care Needs were the subjects of follow-up evaluations conducted in Winter, 1996. The detail of both evaluations are reported on the summary forms that follow.

In brief, the evaluations resulted in predictably declining responsiveness as time from the conference increased (61% after six months for the 1995 conference and 25% after more than one year for the 1994 conference). With already small numbers of potential respondents, caution must be observed in generalizing from any single observed result. However, the overall pattern of both follow-up evaluations was entirely consistent with results obtained in all three evaluations conducted at the 1994-1996 conferences.

In summary, respondents acknowledge the complexity of issues facing them in their attempts to impact inclusion for children with special health care needs who require invasive procedures. They also confirm the conference observations of growth in the population and increasing efforts to address the issues with strategies for information dissemination and collaboration. Funding remains a major constraint in meaningful progress.

Originally, only 11 action plans were completed in the 1995 conference. Seven of those individuals returned follow-up evaluations. The range of progress was none to substantial, including two statewide endeavors of impressive proportions. The dedication of respondents is consistent with that observed for the six month action plan follow-up to the 1994 conference (the subject of an earlier report).

Also consistent with evaluation trends throughout all phases of the project is the acknowledgment of respondents that the conferences meaningfully assisted their effort to address these complex issues. Although the numbers of conference participants were small, they were strongly committed to the issues.3

APPENDICE D

Resource Table Year 03

POLICY AND PRACTICE RESOURCE TABLE

Ordering Information

The following publications are available through:

National Maternal & Child Health Clearinghouse
8201 Greensboro Drive #600
McLean, VA 22101
(703) 821-8955

A Reader's Guide for Parents of Children with Mental, Physical or Emotional Disabilities

MCH Related Federal Programs: Legal Handbooks for Programs Planners (SSI Income for Disabled Children)

Family/Professional Collaboration for Families with Children with Special Health Needs and Their Families

Getting a Head Start on HIV

Developing a Community-based System for Children with Special Health Care Needs and Their Families: An Overview

Project Spoon: Special Program of Oral Nutrition for Children with Special Needs

Legal Issues in Pediatric HIV Practice: A Handbook for Health Care Providers

Children with Special Needs: A Resource Guide

Surgeon General's Report: Children with Special Health Care Needs

Family-centered Health Care for Medically Fragile Children

Parameters for Evaluation and Treatment of Patients with Cleft Lip/Palate Other Craniofacial Anomalies

Circles of Care and Understanding: Support for Fathers of Children with Special Needs

A National Goal: Building Service Delivery Systems for Children with Special Health Care Needs and Their Families

The Open Door: Parent Participation in State Policymaking about Children with Special Health Care Needs
National Health and Safety Performance Standards: Guidelines for Out-of-home Child Care Programs

Families on the Move

The following publications are available through:

Learner Managed Designs PO Box 3067
Lawrence, KS 66046
(913) 842-9088

Home Gastrostomy Care for Infants and Young Children (plus student booklet)

Home Tracheostomy Care for Infants and Young Children (plus student booklet)

Clean Intermittent Catheterization (plus student booklet)

Positioning for Infants and Young Children with Motor Problems (plus student booklet)

Communication with Preverbal Infants and Young Children (plus student booklet)

Feeding Infants and Young Children with Special Needs (plus student booklet)

Home Oxygen for Infants and Young Children

Infection Control in Child Care Settings

Handbook for the Care of Infants and Toddlers with Disabilities and Chronic Conditions

The following publications are available through:

Project School Care
Children's Hospital
300 Longwood Ave
Gardner 610
Boston, NA 02115
(617) 735-6714

Children Assisted by Medical Technology in Educational Settings: Guidelines for Care

Children Assisted by Medical Technology in Educational Settings: Resources for Training

The following publications are available through:

The Legal Center
455 Sherman Street #130
Denver, CO 80203
(800) 332-6356

The Future of Children with Disabilities is in Your Hands: Handbook of Rights to Special Education in Colorado

The Future Hands: Supplement to the Handbook of Rights to Special Education in Colorado: A Guide for Parents

First Steps to Discovery

Other materials from various sources:

AAUAP 1994 Resource Guide
AAUAP
8630 Fenton St., #410
Silver Spring, MD 20910
(301) 588-8252

National Nursing Standards of Nursing Practice for Early Intervention Services
Division of Parent-Child Nursing
College of Nursing

Univ. of Kentucky Chandler Medical Center
Lexington, KY 40536-2322

The Medically Fragile Child in the School Setting (item #451)
American Federation of Teachers
555 New Jersey Ave., N.W.
Washington, DC 20001

Administrator's Policy Handbook for Preschool Mainstreaming
Brookline Books P.O. Box 1046
Cambridge, MA 02238-1046

Managing the School Age Child with a Chronic Health Condition
Sunrise River Press
11481 Kost Dam Road
North Branch, MN 55056
(800) 551-4754

Management of Students with Health Impairments in the School Setting
Illinois State Board of Education
100 North First Street
Springfield, IL 62777-0001

Caregiver Education Guide for Children with Developmental Disabilities
Aspen Publishers, Inc.
200 Orchard Ridge Drive, #200
Gaithersburg, MD 20878
(800) 638-8437

RESOURCES AND REFERENCES

Procedure Guidelines for Health Care of Special Needs Students in the School Setting. Colorado Department of Education and Colorado Department of Public Health and Environment; 1988. (This manual is being revised and expected to be available by October 1994.)

Haynie M., Palfrey J., Porter S. *Children Assisted by Medical Technology in Educational Settings: Guidelines for Care.* Project School Care, The Children's Hospital, Boston; 1989. (This manual is updated periodically.)

Standards of School Nursing Practice. American Nurses Association; 1983.

An Evaluation Guide for School Nursing Practice: Designed for Self and Peer Review. National Association of School Nurses; 1985.

Evaluating School Nursing Practice: A Guide for Administrators. American School Health Association; 1987.

NOTE: The three above publications are a series jointly developed by five nursing organizations and available from American School Health Association.

Guidelines for the Delineation of roles and responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting. Developed by The Joint Task Force for the Management in Children with Special Health Needs; 1990. (Order from The Council for Exceptional Children, Reston VA)

Guidelines for a Model School Nursing Service Program. National Association of School Nurses; 1990

Proctor S., Lordi S., Zaiger D. *School Nursing Practice: Roles and Standards.* National Association of School Nurses; 1993

Enhancing Quality - Standards and Indicators of Quality Care for Children with Special Health Care Needs. Washington DC: US Department of Health & Human Services, Bureau of Maternal and Child Health; 1989.

Infectious Disease in the Child Care Setting: Guidelines for Child Care Providers. Colorado Department of Public Health and Environment; 1990.

Guidelines for School Nursing Documentation: Standards, Issues and Models. National Association of School Nurses; 1992.

Chauvin V. *Students with Special Health Care Needs: A Manual for School Nurses.* National Association of School Nurses; 1994.

APPENDICE E

Conference Program Year 03

SCHEDULE

Third National Conference on Developing Policy and Practice To Implement I.D.E.A. Related to Invasive Procedures for Children with Special Health Care Needs

June 14 - 15, 1996

Sponsored by the University of Colorado Health Sciences Center
School of Nursing

Marilyn J. Krajicek, Ed.D., R.N., F.A.A.N.
Project Director
UCHSC School of Nursing

FRIDAY, JUNE 14, 1996
Morning session

8:00 a.m. Breakfast

8:30 a.m. Welcoming Remarks

Juanita Tate, Ph.D., R.N.
UCHSC School of Nursing
Interim Dean and Associate Professor

8:35 a.m. Introduction: Overview

Defining the Issues
Marilyn Krajicek, Ed.D., R.N., F.A.A.N.
Policy and Practice Project Director
Conference Evaluation
Geraldine Steinke, Ph.D.

9:00 a.m. Keynote Address
Moderator: Marilyn Krajicek, Ed.D., R.N., F.A.A.N.

Reauthorization of I.D.E.A.: Changes for Children with Special Health Care Needs
Brian McNulty, Ph.D.
Assistant to the Commissioner, Colorado Dept. of Ed.

9:45 a.m. Stories of Children with Special Health Care Needs
Moderator: Marie Swigert, R.N., MS

Special Children - Special Families
Tracy Johnson, Parent Advocate
There Have Always Been Nurses
Elaine Angelo, Parent Advocate

10:30 a.m. Refreshment Break

10:45 a.m. Providers on the Frontlines: The Classroom
Moderator: Pat Motz, R.N., Ed.D

Educators' Outlooks
Barbara Brent, M.S., M.Ed.
JFK Center, UCHSC
A Career Perspective
Barbara Riley, Educator, Hamilton School

11:30 a.m. Breakout Session

FRIDAY, JUNE 14, 1996
Afternoon session

12:15 p.m. Lunch

1:30 p.m. Panel: Outlook for the Future
Moderator: Marilyn Krajicek, Ed.D., R.N., F.A.A.N.

Medicaid for Children with Special Health Care Needs
John Nackashi, Ph.D., MD
Medical Director, Pediatric Care
University of Florida

Payors and Providers in the Evolving Health Care System
Jim Carlisle, Marketing Associate
The Children's Hospital, Denver

2:30 p.m. Refreshment Break

2:45 p.m. Discussion Session: The Status of Care
Moderator: Pat Motz, R.N., Ed.D

Resource and Referral Agencies Nationwide
Gail Wilson, President-elect - National Association of Child Care Resource and Referral Agencies

Acuity in the Public Schools
Victoria Hertel, R.N., MS
Colorado School Health Nursing Consultant
National Association of State School Nurse Consultants

3:30 p.m. Accessing Resources
Moderator: Jennifer Burnham

Technical Assistance Resources: Present and Future
Jo Shackelford, R.N., MPH, MA
National Early Childhood Technical Assistance Coordinator
Frank Porter Graham, Child Dev. Ctr., Univ. of N. Carolina

4:00 p.m. Breakout Session

4:45 p.m. Adjournment until Saturday a.m.

SATURDAY, JUNE 15, 1995
Morning session

8:00 a.m. Continental Breakfast

8:30 a.m. The Status of Delegation
Moderator: Dalice Hertzberg, R.N., MSN

A National Survey of Nurse Practice Acts
Marjorie Long, J.D., Legal Consultant

9:15 a.m. Managing Delegation: The Process
Moderator: Marjorie Long, J.D.

Administrative Agencies
Linda Siderius, J.D.
First Assistant Attorney General, State of Colorado

Delegation as a Managerial Concept
Doris Nay, R.N., MA
Associate Executive Director, National Council State Boards of Nursing

10:00 a.m. Establishing Policies and Procedures: Exemplary Programs
Moderator: Marjorie Long, J.D.

The Arkansas Experience
Marcia Harding, MS, CCC
Coordinator, Special Services, Special Ed. Unit

A Statewide Training Protocol
Marie Swigert, R.N., MS
Director, Community Health Nursing, Colo. Dept. of Public Health & Envir.
Dalice Hertzberg, R.N., MSN
Project Coordinator, First Start, UCHSC - SON

Teaming Professionals and Paraprofessionals
Pat Motz, Ed.D., RNC
Consultant, Employee Health Services, Denver Public Schools

11:00 a.m. Refreshment Break

11:15 a.m. Living the Job
Moderator: Marilyn Krajicek, Ed.D., R.N., F.A.A.N.

From Parenting to Outreach
Janice Salmans, Parent Advocate

11:35 a.m. Breakout Session

SATURDAY, JUNE 15, 1995
Afternoon session

12:00 noon Lunch

12:45 p.m. Luncheon speaker
Taking the Political Pulse
Anna Jo Haynes, Executive Director
Mile High Child Care Association

1:30 p.m. Agents of Change
Moderator: Vicky Hertel, R.N., MS

Effecting Change at Different Levels
Sally Phillips, R.N., Ph.D
Past Chair, Colo. State Board of Nursing
Wendy Nehring, R.N., Ph.D
Past President for Nursing, American Assn. on Mental Retardation
Jane Quinn, Community Activist

2:45 p.m. Refreshment Break

3:00 p.m. Testing the Limits of Delegation
Moderator: Marjorie Long, J.D.

California: Taking on Delegation in Childcare
Maria Gil de Lamadrid, J.D.
Staff Attorney, Child Care Law Center

Delegation: Role of Other Professions
Janet Valluzzi, MBA, OTR/L
M-FIRST, Center on Human Dev. & Disabilities
University of Washington

Discussants:
Sally Phillips, R.N., Ph.D, UCHSC
Elaine Angelo, Parent Advocate
Laura Lefkowits, Denver Board of Education

4:00 p.m. Summary

Evaluation of Conference
Technical Assistance Availability
Marilyn J. Krajicek, Ed.D., R.N., F.A.A.N.

4:30 p.m. Conference Adjourns

APPENDICE F

States in Attendance by RRC's

REGIONAL RESOURCE CENTERS (RRC)
and
FEDERAL RESOURCE CENTER (FRC) PROGRAMS

Region #	States Served	States Represented at National Policy & Practice Conference
1. **Northeast RRC (NERRC)**	Connecticut	
H028A30002	Maine	Maine
Edith Beatty, Director	Massachusetts	Massachusetts
Trinity College	New Hampshire	New Hampshire
Colchester Avenue	New Jersey	
Burlington, VT 05401	New York	New York
Tel (802)658-5436	Rhode Island	
Fax (802)658-7435	Vermont	
Internet: Nerrc@delpi.com		
2. **Midsouth RRC (MSRRC)**	Delaware	Delaware
H028A30008	New District of	District of Columbia
Robert Sterrett, Director	Columbia	Kentucky
University of Kentucky	Kentucky	
Mineral Industries Building	Maryland	North Carolina
Lexington, KY 40506-0051	North Carolina	
Tel (606)257-7937	South Carolina	Tennessee
Fax (606)258-1901	Tennessee	Virginia
Internet: Sterretb@uklans.uky.edu	Virginia	West Virginia
	West Virginia	
3. **South Atlantic RRC (SARRC)**	Alabama	Alabama
H028A30005	Arkansas	Arkansas
Timothy Kelly, Director	Florida	Florida
Florida Atlantic University	Georgia	
1236 North University Drive	Louisiana	Louisiana
Plantation, FL 33322	Mississippi	
Tel (305)473-6473-6106/6611	New Mexico	New Mexico
Fax (305)424-4309	Oklahoma	Oklahoma
Internet Kelly_t@acc.fau.edu	Texas	
	Puerto Rico	
	Virgin Islands	

Region #	States Served	States Represented at National Policy & Practice Conference
4. **Great Lakes Area RRC (GLARRC)**	Illinois	Illinois
H028A30004	Indiana	Indiana
Larry Magliocca, Director	Michigan	
Ohio State University	Minnesota	Minnesota
700 Ackerman Road, Suite 440	Ohio	Ohio
Columbus, OH 43202	Pennsylvania	
Tel (614)447-0844	Wisconsin	Wisconsin
Fax (614)447-9043		
Internet: Magliocca.l@osu.edu		
5. **Mountain Plains RRC (MPRRC)**	Colorado	Colorado
H098A30009	Iowa	Iowa
Glenn Latham, Director	Kansas	Kansas
Utah State University	Missouri	Missouri
1780 North Research Parkway,	Montana	
Suite 112	Nebraska	Nebraska
Logan, UT 84321	North Dakota	North Dakota
Tel (801)752-0238	South Dakota	
Fax (801)753-9750	Utah	Utah
Internet: Latham@cc.usu.edu	Wyoming	Wyoming
	Bureau of Indian Affairs	
6. **Western RRC (WRRC)**	Alaska	
H028A30003	Arizona	
Richard Zeller, Director	California	California
1268 University of Oregon	Hawaii	Hawaii
Eugene, OR 97403-1068	Idaho	
Tel (503)346-5641	Nevada	
Fax (503)346-5639	Oregon	
Internet: Richard_Zeller@ccmail.	Washington	Washington
uoregon.edu	American Samoa	
	Guam	
	Northern Marianas	
	Federated States of Micronesia	
	Republics of the Marshall Islands	
	Republic of Palau	

THIRD NATIONAL CONFERENCE ON DEVELOPING POLICY AND PRACTICE TO IMPLEMENT THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT RELATED TO INVASIVE HEALTH CARE PROCEDURES FOR YOUNG CHILDREN

June 14 - 15, 1996

CONFERENCE EVALUATION REPORT

Prepared by Geraldine Steinke, PhD
May, 1996

University of Colorado Health Sciences Center
School of Nursing
Policy and Practice

Executive Summary

June 14 - 15, 1996, in Denver, Colorado, the third national Conference on Developing Policy and Practice was held. The multi-disciplinary forum addressed issues impacting the safe and legal implementation of the Individuals with Disabilities Education Act (IDEA) for young children who require invasive health care procedures. Conference goal attainment was assessed through a comprehensive objectives-driven evaluation, similar to that used for the first two conferences in the series.

Evaluation objectives. Three evaluation objectives were defined:

1. Determination of the effectiveness of efforts to attract a multi-state interdisciplinary audience.

2. Determination of effectiveness in raising awareness of issues pertaining to inclusion and invasive procedures and raising confidence in ability to impact inclusion.

3. Determination of the quality of the conference overall and of its constituent elements.

Method. Four instruments were designed to address the evaluation objectives:

a) The Participant Information Sheet - a descriptive and demographic questionnaire (completed at the start of the conference) examining efforts to attract a multistate interdisciplinary audience (Objective 1).

b) The Pre- and Post-Conference Self Assessments - a Likert-style repeated measure (completed at the start and conclusion of the conference) of awareness of the focal areas addressed in the conference and of confidence in ability to impact implementation of IDEA, including open-ended identification of obstacles and assets in implementation, employed to establish baseline awareness and detect conference impact on focal issues (Objective 2).

c) The Session Rating Form - a Likert-style rating form to assess the quality of each presentation, employed to assess the quality of conference elements (part of Objective 3).

d) The Overall Conference Evaluation - a 14 item questionnaire completed at the conclusion of the conference, including Likert-style rated items about the overall quality of the conference and open-ended questions, employed to assess the conference in its entirety (part of Objective 3).

All four instruments were included in an Evaluation Packet distributed to attendees at registration and collected at the conclusion of the conference. In all rating instruments, a six point scale was used where higher scores reflected more favorably on the conference. Numerical data (ratings and frequencies) were analyzed to yield descriptive statistics and, for the Pre- and Post-Conference Self-Assessments, repeated measures *t*-tests were computed for statistical inference. Open-ended responses were coded for thematic content.

Results. Twenty of 26 (77%) participants returned substantially complete packets (of the 20 respondents, two did not complete the Overall Conference Evaluation and one did not complete the Post-Conference Self-Assessment).

a) Participant Information Sheet. Registrants at the third conference represented 13 states, while speakers represented four additional states[1]. Respondents to evaluation forms were white females (100%). The minimal educational level was the baccalaureate, and half had advanced degrees. Nursing was the modal profession at 45%, although several disciplines and professions were represented including education, administration, child care, and a parent of a child with special needs.

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[1] Together, the first and second conferences attracted a total of 27 states, and the District of Columbia.

b) Pre- and Post-Conference Self Assessments. Post- ratings were significantly higher than Pre- ratings for all items ($p < .05$ or better). Greatest gains were seen in confidence to impact implementation of IDEA, awareness of anticipated changes for children with special health care needs under reauthorization of IDEA, actions and resources to promote safe and legal inclusion, and comprehension of liability issues. Perceived obstacles to implementation of IDEA were: funding, including shortage of nursing resources; lack of knowledge, training and other supports; and attitudinal factors. Assets to implementation included many state- or setting-specific resources, legal delegation, and collaborative endeavors.

c) Session Rating Form. All presentations received positive ratings. Eighteen of the 23 presentations achieved scores above 5, on the six point scale. Participants preferred sessions including parent presentations, the current status of laws, and a model for standardizing medication administration. Strategies, program models, and forecasted national trends were also well received.

d) Overall Conference Evaluation. With the single, but persistent, exception of adequacy of time allotted for the conference, all aspects of the program received high to very high assessments at the close of the conference. Most-valued aspects included the conference as whole, delegation issues, and networking opportunities, whereas tight scheduling was a frequent criticism. Open-ended comments indicated that most participants were motivated to pursue related goals upon return home.

Summary and Recommendations. The final Conference on Developing Policy and Practice, was evaluated within the framework of a comprehensive objectives-driven evaluation similar to that used for the first two conferences. Outcomes assessed included effectiveness in: a) reaching a diverse national audience, b) increasing awareness of focal issues associated with invasive procedures in the safe and legal implementation of IDEA, and, c) delivering high quality content that satisfied participants.

Utilizing four evaluation instruments addressing these objectives, the outcomes included:

1. modest success in reaching a geographically diverse audience (cumulatively, the conference series was effective in this objective attracting participation from 32 states and the District of Columbia). Demographic and professional diversity were less well attained.
2. increased awareness of all focal issues was attained and increased participant confidence in ability to impact inclusion was also achieved.
3. achievement of high quality in the presentations and the conference as a whole.

These findings were consistent with those of preceding conferences in the series, leading to the recommendations that:

1. Dissemination of the conference *Proceedings* be targeted to unrepresented states and among under-represented professions.
2. A summary article or other publication be drafted to describe the issues and outcomes of this conference series to reach a wider audience of educators, policy makers, and advocacy groups.

Conclusion. The outcome of the evaluation of the third Policy and Project Conference provided objective data in support of the conclusion that the conference substantially met its three objectives. In addition, responses to open-ended question on perceived barriers and assets to implementation and personal goals related to the issues indicated that the conference had stimulated participants' assessments of their on settings and strengthened commitment to the issues. Furthermore, the outcomes of the third iteration of the evaluation plan are consistent with those of the preceding two versions (see evaluation reports for 1994 and 1995) in which all stated objectives were achieved, leaving participants energized to take action on these issues upon return to their home states.

Acknowledgements

The author thankfully acknowledges the contributions of Drs. Carolie Coates, Don Soltz, Sandy Larson, and Wendy Nehring for consultation in evaluation planning and instrument design for the first National Conference, which served as the model for the plan used in the Third Conference.

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Table 1. Pre- and Post- Conference Assessments

Table 2. Session Rating Form

Table 3. Overall Conference Evaluation

The Third National Conference on Developing Policy and Practice for the Implementation of the Individuals with Disabilities Education Act (IDEA) related to Invasive Health Care Procedures for Young Children was the final conference in the series of three annual meetings, 1994-1996. The conference was held June 16 -17, 1995, in Denver, Colorado. Its goals were to provide a national, interdisciplinary forum for a multi-faceted exploration of issues such the legality and process of delegation to unlicensed assistive personnel under Nurse Practice Acts, the roles and concerned of involved parties such as parents, administrative agencies, and classroom teachers, and resources that may be called upon to influence inclusion for young children with special health care needs.

A comprehensive evaluation plan was administered for all three conferences to provide objective data for assessment of conference goal attainment. This report describes the outcomes of this process for the third conference including the Evaluation Plan, Evaluation Results, and Summary Recommendations resulting from the conference series.

Evaluation Plan

The evaluation of the Third National Conference was designed to address three evaluation objectives, using four instruments. The objectives, associated instruments, and procedures for administration and data analysis are detailed below.

Evaluation Objectives and Methods

The objectives and the accompanying methods were:

1. To determine the effectiveness of efforts to attract an interdisciplinary audience, a description was compiled of the participants in terms of selected demographic characteristics, level of education, and nature of occupation.

2. To determine effectiveness in raising awareness of major conference issues, pre- and post-conference self-assessments were made of levels of awareness of issues pertaining to inclusion and invasive procedures and confidence in ability to impact implementation of IDEA related to invasive procedures.

3. To determine the quality of the conference overall and of its constituent elements, participants evaluated individual presentations and the conference as a whole.

Instrumentation and Procedures

To address these objectives, four instruments were administered, one of which was completed as a repeated measure.

a) The **Participant Information Sheet** is a descriptive and demographic questionnaire requesting the participant's name, current position title, work address and telephone number, and, in checklist format, nature of current position, highest level of academic work completed, ethnicity and gender, and means of learning about the conference. The form was completed at the beginning of the conference and provided frequency data (e.g., numbers of administrators).

b) The **Pre- and Post-Conference Self Assessments**, a mixed format repeated measure, required ratings of awareness of 14 focal areas addressed in the conference and of confidence in ability to impact IDEA in the home state. Rated items included awareness of: a) state legislation impacting the care of children with special health care needs; b) the status of delegation of nursing tasks in the home state; c) needed amendments to the home state Nurse Practice Act for safe, legal implementation of IDEA; d) resources to assist implementation of IDEA; e) measures needed for pre- and in-service preparation for safe, legal implementation of IDEA; f) resources to assist pre- and in-service training regarding medically invasive procedures; g) funding implications of safe, legal implementation of IDEA; h & i) agency, and individual liability issues relating to safe and legal implementation; j & k) actions that promote systems change, and influence policy to achieve safe and legal implementation; l) changes expected for children with special Health Care Needs under reauthorization of IDEA; m) concerns of classroom educators in meeting the needs of children with special health care needs; and n) the status of Medicaid for children with special health care needs; as well as confidence in ability to contribute to safe and legal implementation of IDEA. Items were rated on a six point Likert-style scale ranging from completely unaware to completely aware, or completely unsure to completely confident, dependent upon content. Two open-ended questions required respondents to identify major obstacles and progress in implementing IDEA in their home states. The Assessments were completed at the beginning of the conference (Pre-) and again at its conclusion (Post-Conference Self-Assessment). The two sets of ratings were subjected to repeated-measures t-tests to detect the impact of the conference. Responses to open-ended questions were coded for thematic content.

c) The **Session Rating Form** assessed the quality of each presentation, using a six point Likert-style rating scale in which higher numbers were more favorable. Participants rated each session at its conclusion. Mean ratings were calculated for each presentation.

d) The **Overall Conference Evaluation** assessed the quality and usefulness of the Conference in a 14 item questionnaire. Nine statements, rated on a six point Likert-style scale, addressed: 1) overall quality of the assembled speakers; 2) educational value of the conference; 3) adequacy of time was allotted for the conference; 4) conference format; 5) clarity of conference objectives; 6) attainment of conference objectives; 7) value of the conference as a forum for interaction; and effectiveness in sensitizing participants to (8a) how parents of children with special needs would prefer to be treated by professionals, (8b) how a child's losses and gains may impact parent interactions with professionals, 9) viewpoints of allied health professionals on delegation of invasive health care procedures. Responses to five open-ended questions identified (10 & 11) the most and least useful aspects of the program, (12) commentary on the appropriateness of presentations, (13) identification of related goals participants hoped to pursue, and (14) other comments. The data were summarized to provide means for each rated questions, with the open-ended responses coded for thematic content.

Each participant received an Evaluation Packet that included the instruments described above. The packets were collected at the conclusion of the conference. The data were analyzed to yield descriptive statistics and, for the Pre- and Post-Conference Self-Assessments, inferential statistics (repeated measures *t*-tests).

Evaluation Results

Twenty of 26 (77%) participants returned substantially complete evaluation packets Complete presentations of descriptive and, where applicable, inferential statistics are presented on the questionnaire forms in the Appendices. The results of the evaluation are presented by instrument.

Participant Information Sheet

The Participant Information Sheet is a descriptive and demographic questionnaire, and the first element in the Evaluation Packet for the conference. The form requested the participant's name, current position title, work address and telephone number (if employed). Checklists were also provided to describe the participant's current position, highest level of academic work completed, ethnicity and gender, and means of learning about the conference. (For a data summary of frequencies and percentages and a descriptive table see Appendix A.)

Demographics

Respondents were all ethnically white. All participants who returned evaluation packets were female, although one registrant was male.

Disciplines/Occupations

Respondents used the checklist of disciplines and occupations to describe the nature of their positions. Although nurses were prevalent (45%), several disciplines and professions were represented. These included: educators (25% of respondents) at various levels including regular and early childhood special education, as well as and university level educators in nursing; administrators (10%); a child care provider (5%); and, a parent of a child with special needs (5%).

Academic Degrees

Half of all responding participants were educated at the baccalaureate levels (mostly in nursing). Of the remainder, 35% held masters' degrees, 5% were engaged in masters; study, and 10% held doctoral degrees. Advanced degrees were accounted for by studies in nursing, administration, applied behavioral sciences

National Representation

Registrants represented 13 states: Arkansas, California, Colorado, Delaware, Kansas, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, Tennessee, Utah, and Wyoming. Additional states were represented by speakers from Florida, Illinois, North Carolina and Washington (state). Cumulatively, the three conferences drew representation from 32 states and the District of Columbia.

Awareness of Conference

Finally, the majority of respondents learned about the conference through distribution of the conference brochure (55%), followed by word-of-mouth (20%), recommendations from past participants (15%) and other sources (10%). As in previous conferences, electronic mail and Internet listings were not productive.

Section Summary

The Participant Information Sheet and registration information revealed that the respondents were drawn from 13 states and had learned of the conference through the brochure or word-of-mouth. They were primarily white females in positions related to nursing, education, and other diverse fields. The baccalaureate level was the minimal education level, while half were educated at the advanced degree level.

Pre- and Post-Conference Self-Assessment

The Pre- and Post-Conference Self Assessments required respondents to rate their levels of awareness of issues addressed in the conference and their confidence in their abilities to impact IDEA in their home states. Open-ended comments were sought to elicit the major obstacles and elements already in place in the implementation of IDEA in their home states.

The Self-Assessment was completed as a repeated measure, addressing the same issues in the pre- and post-conference versions. The questionnaire included 14 items on awareness of the issues and one on confidence in effecting changes related to IDEA. Items were rated on a six point scale ranging from completely unaware to completely aware, or completely unsure to completely confident, dependent upon the item. Of the 26 registrants, 20 (77%) completed the Pre-Conference Self-Assessment and all but one completed the Post-Conference form. Table 1. Pre- and Post-Conference Self-Assessments, displays the means of the Pre- and post-assessments, the difference between them (Pre-Post Diff.), standard deviations (SD), t-test value (t), degrees of freedom (df), and probability level (p) for each item in the repeated measure. (See Appendix B for the complete presentation of descriptive and inferential statistics, including frequencies, and verbatim open-ended responses.)

Ratings

In pre-conference ratings, "awareness" issues ranked as follows (in descending order of familiarity): a) the concerns of classroom educators in meeting the needs of children with special health care needs (PRE Mean = 4.925, SD = 1.173); the status of delegation of nursing tasks in the home state (PRE Mean = 4.800, SD = 1.361); the status of Medicaid for children with special health care needs (PRE Mean = 4.300, SD = 1.418); state legislation impacting the care of children with disabilities with special health care needs (PRE Mean = 4.250, SD = 1.410); needed amendments to the home state's Nurse Practice Act

Table 1. PRE- and POST-CONFERENCE SELF-ASSESSMENTS

Respondents rated the statements below using a six point scale (1 = completely unaware to 6 = completely aware)

Statement	**Pre Mean (SD)**	**Post Mean (SD)**	**Pre-Post Diff. (SD)**	**t**	**df**	**p**
My state's legislation impacting the care of children with disabilities with special health care needs.	**4.250 (1.410)**	**5.079 (0.976)**	**0.816 (1.145)**	**3.105**	**18**	**.006**
The status of delegation of nursing tasks in my state.	**4.800 (1.361)**	**5.421 (0.769)**	**0.684 (1.204)**	**2.477**	**18**	**.023**
Needed amendments to my state's Nurse Practice Act for safe, legal implementation of I.D.E.A.	**4.200 (1.609)**	**5.000 (0.745)**	**0.895 (1.243)**	**3.139**	**18**	**.006**
Resources available to assist implementation of I.D.E.A. in my state.	**4.125 (1.503)**	**5.289 (0.652)**	**1.237 (1.358)**	**3.971**	**18**	**.001**
Measures needed for pre- and in-service preparation for safe, legal implementation of I.D.E.A. in my state.	**3.925 (1.541)**	**5.237 (0.752)**	**1.395 (1.254)**	**4.849**	**18**	**.000**
Resources available to assist pre- and in-service training regarding medically invasive procedures.	**3.650 (1.470)**	**5.000 (0.976)**	**1.386 (1.268)**	**4.706**	**18**	**.000**
Funding implications of safe, legal implementation of I.D.E.A. in my state.	**3.600 (1.353)**	**4.500 (1.014)**	**0.868 (1.508)**	**2.511**	**18**	**.022**
Agency liability issues relating to safe, legal implementation of I.D.E.A.	**3.725 (1.371)**	**4.816 (0.837)**	**1.053 (1.141)**	**4.020**	**18**	**.001**
Individual liability issues relating to safe, legal implementation of I.D.E.A.	**3.950 (1.504)**	**5.237 (0.832)**	**1.342 (1.510)**	**3.875**	**18**	**.001**

Table 1. **PRE- and POST-CONFERENCE SELF-ASSESSMENTS** (continued)

Statement	Pre Mean (SD)	Post Mean (SD)	Pre-Post Diff (SD)	t	df	p
Actions that can promote systems change to achieve safe and legal implementation of I.D.E.A. in my state.	3.700 (1.525)	4.947 (0.621)	1.316 (1.336)	4.294	18	.000
Actions that can influence policy to achieve safe and legal implementation of IDEA in my state.	3.500 (1.395)	4.816 (0.901)	1.395 (1.276)	4.766	18	.000
s expected for children with special Health Care Needs under reauthorization of IDEA	3.400 (1.353)	4.868 (0.814)	1.500 (1.041)	6.282	18	.000
The concerns of classroom educators in meeting the needs of children with special health care needs.	4.925 (1.173)	5.342 (0.625)	0.447 (0.926)	2.105	18	.050
The status of Medicaid for children with special health care needs.	4.300 (1.418)	5.079 (0.786)	0.763 (1.358)	2.450	18	.025
Ability to contribute to safe, legal implementation of I.D.E.A. in my state.[2]	3.579 (1.644)	5.059 (0.982)	1.588 (1.049)	6.241	16	.000

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[2] This item was rated on a six point Likert scale expressing the respondent's confidence in ability to effect the item:

1 = completely unsure
2 = somewhat unsure
3 = slightly unsure
4 = slightly confident
5 = somewhat confident
6 = completely confident

for safe, legal implementation of IDEA (PRE Mean = 4.200, SD = 1.609); resources available to assist implementation of IDEA (PRE Mean = 4.125, SD = 1.503); individual liability issues relating to safe, legal implementation of IDEA (PRE Mean = 3.950, SD = 1.504); measures needed for pre- and in-service preparation for safe, legal implementation of IDEA in my state (PRE Mean = 3.925, SD = 1.541); agency liability issues relating to safe, legal implementation of IDEA relating to safe, legal implementation of IDEA (PRE Mean = 3.725, SD = 1.371); actions that can promote systems change to achieve safe and legal implementation of IDEA in my state (PRE Mean = 3.700, SD = 1.525); resources available to assist pre- and in-service training regarding invasive health care procedures (PRE Mean = 3.650, SD = 1.470); funding implications of safe, legal implementation of IDEA in my state (PRE Mean = 3.600, SD = 1.470); actions that can influence policy to achieve safe and legal implementation of IDEA in my state (PRE Mean = 3.500, SD = 1.395); and, changes expected for children with special Health Care Needs under reauthorization of IDEA (PRE Mean = 3.400, SD = 1.353).

Upon post-conference assessment, all of the awareness ratings identified in the preceding paragraph had improved (as indicated in two-tailed, paired t-tests). Reviewing pre-post comparisons of items significant at the .000 level of probability in two-tailed t tests, participants left the conference more aware of (in order of magnitude of the pre-post mean differences): a) changes expected for children with special health care needs under reauthorization of IDEA (Diff = 1.500, SD of diff = 1.041); measures needed for pre- and in-service preparation (Diff = 1.395, SD of diff = 1.254); actions that can influence policy (Diff = 1.395, SD of diff = 1.276); resources available to assist pre- and in-service training

(Diff = 1.386, SD of diff = 1.268); actions that can promote systems change (Diff = 1.316, SD of diff = 1.336). At the .001 level, the items ranked as follows: individual liability issues (Diff = 1.342, SD of diff = 1.510); resources available to assist implementation of IDEA (Diff = 1.237, SD of diff = 1.358); and, agency liability issues (Diff = 1.053, SD of diff = 1.141). At the .05 level or better, awareness increased of: needed Nurse Practice Act amendments (Diff = 0.895, SD of diff = 1.243); related state legislation (Diff = 0.816, SD of diff = 1.145); funding implications (Diff = 0.868, SD of diff = 1.508); the status of Medicaid for children with special health care needs (Diff = 0.763, SD of diff = 1.358); the status of delegation in the home state (Diff = 0.684, SD of diff = 1.204); and, concerns of classroom educators (Diff = 0.447, SD of diff = 0.9926). The remaining rated item, confidence in the ability to contribute to safe and legal implementation of IDEA in the home state, received an initial mean rating of 3.579, on the six point scale, placing it just barely on the positive side of the continuum. Upon post-assessment, it was significantly higher ($p <$ .000), with the largest pre-post mean difference (1.588) of all rated items.

Open-ended Comments

Two open-ended questions addressed awareness of obstacles and assets to implementation of IDEA in the home states (pre-conference assessment) and whether the conference helped in identification of these factors (post-conference assessment). Among the obstacles cited in the pre-conference forms were funding, lack of knowledge, training and other support, and attitudinal factors. Twelve comments cited funding and, among these 12, five referred to shortages of appropriate nursing resources for delegation and supervision. Issues related to delegation including restrictive nurse practice acts or regulations, ignorance of the acts, or lack of knowledge and skills related to the process of delegation were addressed in five comments. Another five cited education administrators (superintendents and principals) as barriers, while three comments noted attitudinal issues including fear and apprehension on the part of educators and some health care staff, as well as overt resistance. Absence of adequate support and training for providers of procedures was also cited a number of times.

At the post-conference assessment, 13 of 19 respondents (68%) were able to identify additional barriers as a result of participation in the conference. Three respondents each cited: a) issues pertaining to delegation; b) increased awareness of child care issues; and, c) increased awareness of the numbers of involved parties and disciplines including parent experiences and the roles and perspectives of allied health professionals. Singular mention was made of the need for more thorough training of paraprofessionals, increased awareness of attitudes, and the need for education regarding laws.

At the pre-conference assessments, assets and resources in place included: a) specific programs (e.g., Part H) and resources for knowledge and training (e.g., the School of Nursing of the University of Colorado Health Sciences Center); b) permissibility of delegation under prevailing nurse practice acts (five references); c) ongoing interagency or interdisciplinary collaboration in the form of task forces or policy setting groups, or as an orientation for problem-solving (five references); d) knowledgeable resource individuals (e.g., state school nurse consultant)(four references); e) ongoing inclusive practices (two references); and, f) availability of Medicaid to support related services (two references). Singular comments noted strong parent support and advocacy, school districts' use of contract nurses for preschools, IEPs, and provision of therapies in schools.

Among assets brought to the participants' attention by the conference were: strategies and resources presented at the conferences (e.g., NEC*TAS, child care R&R, handouts) (six references); more awareness and understanding of the prevailing nurse practice act or how the act should be amended (five references); networking possibilities with other states and individuals (four references);awareness of more parties to involve in policy making and implementation (two references); and, First Start training (a paraprofessional training program offered by the School of Nursing of the University of Colorado Health Sciences Center University) (two references). Finally, noted once each were the importance of participation with the State Board of Nursing and State Association of School Nursing, and awareness of the need to regulate OTC (over-the-counter) medication administration.

Section Summary

At the pre-conference assessment, respondents rated their confidence fairly low in their own abilities to impact implementation of IDEA. They were least aware of anticipated changes for children with special health care needs under the reauthorization of IDEA, and of actions and resources to promote safe and legal inclusion. Post-conference means were significantly higher than Pre- ratings for all rated items at the .05 level of significance or better, with the largest mean differences observed for confidence to impact inclusion and awareness of IDEA reauthorization issues, followed by increased knowledge of actions and resources and better comprehension of liability issues.

Chief among obstacles to implementation were: funding (including consequent shortage of nursing resources), lack of knowledge, training and other support, and attitudinal factors, with most respondents reporting awareness of additional obstacles by the end of the conference. Assets to implementation included many state- or setting-specific resources, legality of delegation, and interdisciplinary or interagency collaboration. As with barriers, the conference was perceived as heightening awareness or providing many additional resources to most respondents.

Session Rating Form

All 20 of the conference participants who returned evaluation packets completed session ratings for all or most of the sessions (the lowest number of individuals rating any single session was 17, observed for three of the final four speakers). All presentations were rated for quality on a six point rating scale ranging from 1 (very unfavorable) to 6 (very favorable). Table 2, Session Rating Form, presents the item mean (M), standard deviation (SD), and number of respondents rating the session (N).

Ratings

By way of overview, of the 23 presentations, no presentation received a mean rating below 4 (slightly favorable): 22% were rated at 5.5 or higher on the six point scale, indicative of very high quality; 56% were rated 5.0 or higher, indicative of high quality; and 17% tended toward high ratings (between 4.9 and 4.8), while one session was rated "slightly high" quality (Mean = 4.5).

The highest rated sessions were *There Have Always Been Nurses* (Angelo) and *Living the Job* (Salmans), presentations by parents who were first time speakers. Also among the top rated sessions were *Survey of Nurse Practice Acts* (Long), *Special Children/Special Families* (Johnson, another parent speaker), and *Medication Training Protocol* (Swigert & Hertzberg). In the next tier were *Other Professions and Delegation* (Valluzzi), *Reauthorization of IDEA*

(McNulty), *Child Care in California* (Gil de Lamadrid), *Change Agent at the State Level* (Phillips), *Educators' Outlooks* (Brent), *Strategies for Working with Administrative Agencies* (Siderius), *Community Activism* (Quinn, parent of a child with special needs), *Delegation as Management* (Nay), *Medicaid and CSHCN* (Nackashi), *Teaming Professionals and Paraprofessionals* (Motz), *Arkansas Experience* (Harding), *Taking the Political Pulse* (Daley), and *Evolving Health Care Payer/Provider Markets* (Carlisle). Lower but still positive ratings were obtained for *Acuity Instrument for Schools* (Hertel), *Technical Assistance Resources* (Shackelford), *Change Agent: National Organization* (Nehring), *Resource and Referral* (Wilson), and finally *Educator's Career Perspective* (Riley, a classroom teacher and also a first time conference speaker).

SESSION RATING FORM

Please use the scale below to rate the overall quality of each presentation.

1 = very low
2 = low
3 = slightly low
4 = slightly high
5 = high
6 = very high

SPEAKER(S)	Mean rating	Standard deviat'n	N
B. McNulty/ Reauthorization of IDEA	5.450	0.686	20
T. Johnson/ Special Children	5.500	0.513	20
E. Angelo/ Always Been Nurses	5.700	0.470	20
B. Brent/ Educators' Outlooks	5.350	0.671	20
B. Riley/ Career Perspective	4.474	1.124	19
J. Nackashi/ Medicaid for CSHCN	5.150	0.746	20
J. Carlisle/ Payers and Providers	5.050	0.826	20
G. Wilson/ Resource and Referral	4.850	0.745	20
V. Hertel/ Acuity Schools	4.950	0.826	20
J. Shackelford/ Technical Assistance	4.900	0.912	20
M. Long / Nurse Practice Acts	5.658	0.746	10
L. Siderius/ Administrative Agencies	5.342	1.001	19
D. Nay/ Delegation as Management	5.263	0.991	19
M. Harding/ Arkansas Experience	5.100	1.165	20
M. Swigert & D. Hertzberg/ Protocol	5.500	0.601	19
P. Motz/ Teaming Pro's and Paras	5.150	1.040	20
J. Salmans/ Parenting to Outreach	5.684	0.582	19
Martha Daley/ Political Pulse	5.056	1.056	18
S. Phillips/ Change Agent: State	5.389	0.698	18
W. Nehring/ Change Agent: National	4.882	0.928	17
J. Quinn/ Change Agent: Community	5.294	0.686	17
M. Gil de Lamadrid/ CA Child Care	5.444	0.705	18
J. Valluzzi/ Other Professions	5.471	0.624	17

Section Summary

Review of the mean scores revealed that 18 of the 23 presentations achieved scores above 5 on the six point scale. None of the sessions were rated unfavorably.

Participants provided the most favorable ratings for sessions describing parent presentations that revealed the perspectives and of families of children with special needs, the current status of the law, and a model for standardizing medication administration, a problem crossing both school and child care settings. Presentations that provided strategies, models, and forecasted national trends fell in the middle ground. Most of the lower (but still positively) rated presentations were more narrow in their potential applications.

Overall Conference Evaluation

The Overall Conference Evaluation, a 14 item questionnaire, required respondents to provide feedback regarding the quality and usefulness of the Policy and Practice Conference. Nine statements were rated on a six point Likert-style scale ranging from "strongly disagree" to "strongly agree", where higher scores reflected more favorable attitudes. The remaining five questions were open-ended requests for identification of the most and least useful aspects of the program, for commentary on the overall level of presentations, and for suggestions for future conferences. Twenty-two of 23 participants (96%) who returned evaluation packets completed Overall Conference Evaluations (one individual did not complete any post-conference assessments). Table 3 displays Overall Conference Evaluation means for each item.

Rated Items

All but one rated item achieved scores of at least 5.0 on the six point rating scale indicating a high level of satisfaction with the conference. Respondents strongly agreed that:

the overall quality of the speakers was excellent, with 100% choosing 5 (28%) or 6 (72%) (Mean = 5.722, SD = 0.461); the educational value of the conference was excellent (Mean = 5.611, SD = 0.608); presentations heightened awareness of how parents of children with special needs would like to be treated by professionals and how children's gains and losses may impact parent interactions with professionals (equally rated with Means = 5.529, SDs = 0.624); and, that the conference provided a needed forum to address implementation of IDEA (Mean = 5.500, SD = 0.632). The conference was seen as: having an effective format and clear objectives (both rated equally, Mean = 5.389, SD = 0.698); meeting its objectives (Mean = 5.278, SD = 0.826); and, raising awareness of the viewpoints on key issues of allied health professionals (Mean = 5.000, SD = 0.935).

TABLE 3

MEAN RATINGS OF OVERALL CONFERENCE EVALUATION ITEMS

Items were rated on a six point Likert-style scale where 1 = strongly disagree, and 6 = strongly agree.

Item	Mean	SD	N
The overall quality of the speakers was excellent.	5.722	0.461	18
The educational value of the conference was excellent.	5.611	0.608	18
Sufficient time was allotted for the conference.	4.667	1.372	18
The conference format was very effective.	5.389	0.698	18
The objectives for this conference were clear.	5.389	0.698	18
The conference met its objectives.	5.278	0.826	18
The conference provided a needed forum to interact with other concerned individuals from across the country about issues surrounding the safe, legal implementation of IDEA.	5.500	0.632	16
Did the parent presentations in this conference heighten your awareness of:			
a. How parents of children with special needs would like to be treated by professionals	5.529	0.624	17
b. How parents' experiences with their children's gains and losses may impact interactions with professionals	5.529	0.624	17
Did the conference heighten your awareness of the viewpoints of allied health professionals (e.g., OTs, RTs) on issues of performance and delegation of invasive health care procedures?	5.000	0.935	17

Open-ended Responses

Most Useful Aspects. The most frequent reference was to issues and solutions concerning delegation (five references). Networking time and the opportunities to exchange ideas and solutions was next most often cited (three references), followed by presentations referencing legal issues (cited twice). Finally, four respondents noted such general comments as "all of it" or referred to the quality and variety of the speakers.

Least Useful Aspects. With references by five respondents, only one element emerged as a consistent response to this question -- the full conference schedule and the constraints it imposed. Singular responses noted the legal aspects of delegation, managed care and insurance information, the change agent presentations, and the Arkansas model of implementation, and the first day's presentations.

Presentation Levels. All of the respondents felt that the level of presentations met their needs. Although several respondents chose to elaborate their opinions, no consistent pattern emerged in these comments. Two respondents felt that some presentations assumed more knowledge than the participants possessed, while three found some presentations more elementary than they desired. Two caveats to otherwise complimentary comments were noted. One raised annoyance with the time constraints and the second expressed a desire for more information on implementing practices in the least restrictive environment under IDEA. In two comments of a more positive nature, one recognized presentations of personal experiences and how goals were achieved as valuable (one comment), while the other described the overall program as "excellent"!

Future Actions. Twelve of the 18 respondents to the Overall Conference Evaluation commented on pursuit of goals related to the conference issues. Among the responses was one well-detailed plan (given the constraints of the evaluation form) by a state level coordinator for special education who planned to pursue inclusion for children with special needs in the LRE. A more common response included plans to engage in research on related issues such as child care regulations, nurse practice acts, model programs, and best practices. Policy development on delegation was the theme in two plans (one general and one specifically related to medication administration by child care providers), while another individual planned to improve communication between paraprofessionals and RNs and to ensure accuracy of health care plans. Education of nurses and paraprofessionals regarding delegation and training paraprofessionals (foster parents) in caring for children with special needs in an interdisciplinary curriculum were also each noted once.

Less specific plans included application of knowledge of the laws and suggestions for improved communication skills to promote change, and conviction to become a stronger child advocate in interactions with administration. Three respondents wrote comments that were either very general (e.g. "promote inclusion") or expressed uncertainty about what they would do, although one of expected dissemination of conference at the worksite to result in a related goal.

Other Comments. About half the respondents to the Overall Conference Evaluation made closing comments. Six comments were remarks about the conference scheduling and logistics: three that reiterated the desire for more time or fewer speakers in the allotted time; a fourth that suggested more discussion leaders; a fifth wanted copies of the ADA, IDEA, and "delegation" (although each participant received a copy of the most up-to-date nurse practice act available for their state); and a sixth who remarked "Superb logistics!" Singular criticisms included a desire for hands-on guidelines for medical inclusion of special health care children under IDEA; more exemplary programs serving students in LRE, more attention to programs in states other than Colorado, and attention to pharmacology issues and dietary needs. One respondent suggested statewide systems change grants focused on promoting the inclusion in the LRE for children with severe disabilities. Finally, one respondent expressed thanks for "a wonderful conference" and a second wanted to see the project re-funded.

Section Summary

The ratings and comments provided to the Overall Conference Evaluation reveal that the majority of respondents were highly satisfied with the Policy and Practice Conference content and outcomes. Rated statements received mean scores that were highly positive. Frequently cited "most valued aspects" included the conference as whole, delegation issues, and networking opportunities. The major criticism focused on the tight scheduling of sessions. Responses to the inquiry about future plans indicated that the conference had stimulated most participants to pursue related issues upon return home.

Objectives Assessment and Recommendations

The evaluation plan for the Third Conference on Developing Policy and Practice focused on three evaluation objectives:

1. Determination of the effectiveness of efforts to attract an interdisciplinary audience.
2. Determination of effectiveness in raising awareness of issues pertaining to inclusion and invasive procedures and raising confidence in ability to impact inclusion.
3. Determination of the quality of the conference overall and of its constituent elements.

Objective 1

A description of conference participants was compiled using the Participant Information Sheet and registration information to assess the effectiveness of efforts to attract an interdisciplinary audience. The results revealed reasonable success in attracting geographic diversity for the third conference since 17 states were represented (by registrants and speakers), bringing the cumulative total for the first two conferences to 32 states and the District of Columbia. Demographically, the respondents were more homogeneous (white females). All were educated the baccalaureate level or higher. As in the first two conferences, nursing was the modal profession represented (48% of evaluation respondents), a reasonable response to a program presented by a School of Nursing. In the third conference, the percentage of nurses compared to other disciplines was the lowest in the series. Although more diversity was desired, acceptable representation levels were achieved for many disciplines, with the notable exception of medicine. Finally, brochures and word-of-mouth were the most effective advertisements for the conference, consistent with outcomes for the previous two years.

Objective 2

Pre- and Post-Conference Self Assessments of awareness of conference issues and confidence in abilities to impact IDEA in participants' home states, as well as identification of major obstacles and progress or strategies in place to facilitate inclusion, address Objective 2. All post-conference ratings were significantly increased over pre-conference levels with greatest gains in confidence to impact implementation, awareness of anticipated changes under reauthorization of IDEA, actions and resources to promote safe and legal inclusion and comprehension of liability issues. In addition, by the post-conference assessment many respondents reported awareness of additional barriers and resources. Thus, pre-post comparisons revealed significant increases in awareness of the conference issues, as well as gains in confidence in ability to contribute to implementation of IDEA in the home states. The results of the Self-Assessments indicate significant success in achieving the major conference objective of raising awareness of the issues and strategies.

Objective 3

Participants' perceptions of the quality of the conference (of its component elements and of the overall experience) were evaluated using the Session Rating Form and Overall Conference Evaluation. All presentations were favorably rated, as 18 of the 23 ratings achieving means in the high or very high quality range, with preference shown for parent presentations, the status of laws, and a model for standardizing medication administration. In the Overall Conference Evaluation, excepting time allotted for the conference, all aspects of the program received high to very high assessments, with favorable comments for the program in its entirety, delegation issues, and networking opportunities. Comments also revealed that most participants were motivated to pursue related issues upon return home. As in the previous two years' evaluations, objective three, a high quality program, was clearly achieved.

Evaluation Recommendations

Based on the consistent, cumulative findings of the evaluation of this conference series, it is recommended that:

1. Dissemination of the conference *Proceedings* be targeted:

   to unrepresented states and among under-represented professions.

2. A summary article or other publication be drafted to describe the issues and outcomes of the conference series to reach a wider audience of educators, policy makers and advocacy groups.

Summary

The final Conference on Developing Policy and Practice, held June 14 - 15, 1996, in Denver, Colorado, addressed the IDEA as it relates to invasive procedures required by some young children with special health care needs. Consistent with the comprehensive objectives-driven evaluation used for the first two conference, the 1996 conference was evaluated for its effectiveness in reaching a diverse national audience, in increasing awareness of focal issues associated with invasive procedures in the safe and legal implementation of IDEA, and in delivering high quality content that satisfied participants.

Utilizing four instruments designed to address these objectives, the evaluation results indicated that:

1. The third conference was modestly successful in reaching a geographically diverse audience, although cumulatively, the three conference were effective in this objective attracting participation from 32 states and the District of Columbia. Less success was achieved in attracting demographic and professional diversity.
2. The conference was very successful in increasing awareness of focal issues and in increasing participant confidence in ability to impact inclusion.
3. Presentations were favorably rated and participants were very satisfied with the conference as a whole.

Thus, the outcomes of the evaluation of the Policy and Project Conference provided objective data in support of the conclusion that the third conference substantially met its objectives. In addition, responses to open-ended questions on perceived barriers and assets to implementation and future goals related to the issues indicated that the conference had stimulated participants' assessments of their own settings and strengthened commitment to the action. Furthermore, the outcomes of the third iteration of the evaluation plan are consistent with those of the preceding two versions (see evaluation reports for 1994 and 1995) in which all stated objects were achieved.

Appendices

Appendix A

Participant Information Sheet

PARTICIPANT INFORMATION SHEET
June 14-15, 1996

Items 1 - 4 sought the participant's name, title, address, and phone. The information is listed in the following Table.

Instructions: Please provide the following information so that we may meet the reporting requirements of our funding grant for descriptive and follow-up information.

5. Please indicate your discipline/interest group: (Check one)

N	%	
(1)	(5)	early childhood educator
(1)	(5)	early childhood special educator
(3)	(15)	other educator
(-)	(-)	social worker
(1)	(5)	child care provider
(9)	(45)	nurse
(1)	(5)	health department staff
(-)	(-)	medical foster parent coordinator
(-)	(-)	child care director
(-)	(-)	developmental disabilities/special education coordinator
(-)	(-)	psychologist
(-)	(-)	speech therapist/specialist
(-)	(-)	physical therapist
(-)	(-)	occupational therapist
(1)	(5)	parent
(-)	(-)	physician
(-)	(-)	staff development/training/inservice coordinator
(2)	(10)	administrator
(-)	(-)	other

6. Please indicate the highest level of academic work completed: (Check one.)

N	%	
(-)	(-)	No earned diploma
(-)	(-)	GED
(-)	(-)	High school diploma
(-)	(-)	Some college but no degree
(-)	(-)	Associate degree/community college degree
(-)	(-)	LPN
(-)	(-)	RN
(10)	(50)	Bachelor's degree
(7)	(35)	Master's
(1)	(5)	master's degree in progress
(2)	(10)	PhD or other doctorate
(-)	(-)	EdD
(-)	(-)	MD
(-)	(-)	Law Degree
(-)	(-)	Other

7. Ethnicity: (Check one.)

N	%	
(-)	(-)	American Indian/Alaskan Native
(-)	(-)	Asian/Pacific Islander
(-)	(-)	African American
(20)	(100)	Caucasian
(-)	(-)	Hispanic
(-)	(-)	Other

8. Gender: (Check one.)

(20) (100%) Female (-) Male

9. Please indicate how you learned of this conference (check one):

N	%	
(11)	(55)	Brochure mailing
(-)	(-)	Electronic mail/Internet
(3)	(15)	Recommended or sent by a participant in 1994 conference
(4)	(20)	Word-of-mouth
(2)	(10)	Other

p&p96des.Sum

Policy and Practice - June, 1996 (Conference #3)

Part	Name	Title	Address	Phone	Pos'n	Ed'n	Eth'y	Sex	Ref'd
01	Evenson, Kris	Health Coordinator, Poudre Sch.Dist.	703 E.Prospect Ft. Collins, CO 80525	blank	nurse, early childhood, incl'g Sp.Ed & Head Start through	RN MS	Cauc.	f	brochure
02	MacDonald, Beth	Parent of child with special needs ICC Part H rep.	635 West Fairfield Dover, DE 19901	(302)697-1976	early ch. ed. & special ed Parent	bachelor's 30+ hrs college & statewide inservices	Cauc.	f	brochure
03	Hoffart, Marita	Associate Professor	Minot State Univ. 500 W. Univ. Minot, ND 5807	(701)858-3253	PNP/educator in Child Health/UAP	PhD - nursing	Cauc.	f	brochure
04	Patchen, Karen	School Nurse Practitioner	8965 E. Florida #13304 Denver, CO 80231	(303)337-9483	nurse	bachelor's - nursing	Cauc.	f	brochure
05	Iverson, Carol, J.	NE School & Adol. Consultant	301 Continental Mall So. Lincoln, NE 68509-5107	(402)471-0160	nurse - State School Nurse Consult.	master's - Human Behavior & Nursing	Cauc.	f	brochure
06	Day, Sandra	Director	1111 Van Ness Fresno, CA 93721	(201)265-3026	Admin. / Director of Health Svcs, Fresno County Office of Ed.	master's - educ. admin.	Cauc.	f	brochure
07	Lawson, Dorothy Ann	School Nurse	Kent Co. Community School Carver Rd. Dover, DE 19904	(302)672-1962	nurse - school serving children with multiple impairments	bachelor's - nursing	Cauc.	f	word-of mouth
08	Mintle, Beth	RN, School Nurse	66 Jefferson St.	(719)488-	nurse - school	RN and bachelor's	Cauc.	f	brochure

			Monument, Co 80132	4770	nurse	in science			
09	Coats, Donna L.	Resource Nurse for Sp. Ed - APS	120 Woodland NW Albuquerque, NM 87107	(505)345-8531 x363	nurse- school nursing with special needs students	RN & bachelor's in nursing	Cauc.	f	word-of-mouth
10	Bauter, Letha	Coordinator for Sp. Ed.	250 N. Lincoln Blvd. Oklahoma City, OK 73105	(405)521-3351	State Dept. of Ed., Coordinator	master's - applied behavioral sciences in ed.Cauc.	Cauc.	f	brochure
11	Faulkner, Melissa	Asst. Professor & Chief of Nursing	U. of TN Boling Center for Dev. Disabilities College of Nursing 877 Madison, Memphis, TN 38163	(901)448-6139	nurse, pediatric faculty	RN DSN(Doctor of Science in Nursing)	Cauc.	f	brochure
12	Burnham, Jennifer	Prog. mgr. of CO Options for Inclusive Care	CORRA 7853 E. Arapahoe Rd. #3300 Englewood, CO 80112	(303)290-9088	Child care Resource & Referral	bachelor's in Elem. ed.	Cauc.	f	recommended by past participant
13	Cox, Judith	RN-VNA- children with special needs home care	1751 Shavane Longmont, CO 80501	(303)678-1395	school nurse in sp. ed.	bachelor's in nursing	Cauc.	f	Univ. advisor
14	Yuber, Heather	Infant Interventionist	2020 E. 12th Casper, WY 882601	(307)235-5097	nurse, infant early intervention/parenting	bachelor's-nursing	Cauc.	f	brochure
15	Erkenbrack, Lysa	School Nurse Consultant/PNP student	8505 Meadowlark Dr. Lakewood, CO 80226	(303)274-6665	nurse	master's degree student - nursing	Cauc.	f	Univ. advisor
16	Claassen, Marjanne	RN- Kidstreet (The Children' s Hospital)	2234 Osceola St. Denver, CO 80212	(303)480-1023	nurse- medically fragile day care	bachelor's - nursing	Cauc.	f	word-of-mouth
17	Hendrickson,	Director, Infant Dev,	44 No. Medical	( )584-	health dept. staff	bachelor's -	Cauc.	f	brochure

	Shanna	Proj.	Dr. Salt Lake City, UT 84114	8226		nursing, master's student			
18	Hertzberg, Dalice	Project Coordinator-RN	First Start UCHSC SON Box C-287 4200 E. Ninth Ave Denver, CO 80262	(303)270-3862	nurse- pediatric, SON & UAP	master's - nursing	Cauc.	f	other (worked on project)
19	Riley, Barbara, J.	teacher	86000 E. Dartmouth Ave. Denver, CO 802316	(303)755-1267	educator - middle school spec. ed	bachelor's in spec.ed (TMR & EMR) & elementary	Cauc.	f	word-of-mouth
20	Nay, Doris	Associate Exec, Dir.	National Council of State Brds of Nursing 676 N. ST Clair Suite 550 Chicago, IL 60611	(312)787-6555 x166	nurse (regulation)	master's nursing ed.	Cauc.	f	other (project advisor)

Appendix B

Pre- and Post-Conference Self-Assessments

PRE/POST-CONFERENCE SELF-ASSESSMENTS

June, 1996

Listed below in bold type beneath each question is a summary of the responses provided by the 20 conference attendees who returned evaluation packets. Pre-conference descriptive statistics are based upon 20 respondents. Since one respondent did not complete post-conference assessments, the sample size for Post-conference descriptive statistics and for the pre-post comparison are based on 19 respondents. Pre- and post-conference self-assessments of awareness and confidence are labelled in capitals, presenting the frequency (freq.) of response in each category, the percentage of respondents (%) selecting each alternative, the mean score for the item (M), the standard deviation (SD) and the number of respondents who answered (N). Paired t-test results are also reported for each item showing significance of differences in the pre- and post- assessments. The mean difference (Diff), standard deviation (SD), test statistic (t), degrees of freedom (df), and probability level (p) are listed. All tests were two-tailed. Open-ended comments are provided verbatim.

Items were rated using the following six point scale:

1 = completely unaware
2 = somewhat unaware
3 = slightly unaware
4 = slightly aware
5 = somewhat aware
6 = completely aware

1. My state's legislation impacting the care of children with disabilities with special health care needs.

				unaware					*aware*
				1	2	3	4	5	6
PRE	**Mean = 4.250**	**SD = 1.410**	**freq**	**-**	**4**	**1**	**5**	**6**	**4**
		N = 20	**%**	**-**	**20**	**5**	**25**	**30**	**20**
POST	**Mean = 5.079**	**SD = 0.976**	**freq**	**-**	**-**	**2**	**3**	**6**	**8**
	N = 19		**%**	**-**	**-**	**10**	**16**	**33**	**42**

PRE-POST Comparison

Diff = 0.816 SD of diff = 1.145 t = 3.105 df = 18 p<.006

2. The status of delegation of nursing tasks in my state.

				1	2	3	4	5	6
PRE	**Mean = 4.800**	**SD = 1.361**	**freq**	**-**	**1**	**3**	**5**	**1**	**10**
	N = 20		**%**	**-**	**5**	**15**	**25**	**5**	**50**
POST	**Mean = 5.421**	**SD = 0.769**	**freq**	**-**	**-**	**-**	**3**	**5**	**11**
	N = 19		**%**	**-**	**-**	**-**	**16**	**26**	**58**

PRE-POST Comparison

Diff = 0.684 SD of diff = 1.204 t = 2.477 df = 18 p <.023

unaware *aware*

3. Needed amendments to my state's Nurse Practice Act for safe, legal implementation of IDEA.

			1	2	3	4	5	6
PRE	**Mean = 4.200 SD = 1.609**	**freq**	**1**	**3**	**3**	**2**	**6**	**5**
	N = 20	**%**	**5**	**15**	**15**	**10**	**30**	**25**
POST	**Mean = 5.000 SD = 0.745**	**freq**	**-**	**-**	**-**	**5**	**9**	**5**
	N = 19	**%**	**-**	**-**	**-**	**26**	**47**	**26**

PRE-POST Comparison

Diff = 0.895 SD of diff = 1.243 $t = 3.139$ $df = 18$ $p < .006$

4. Resources available to assist implementation of IDEA in my state.

			1	2	3	4	5	6
PRE	**Mean = 4.125 SD = 1.503**	**freq**	**2**	**5**	**3**	**6**	**1**	**3**
	N = 20	**%**	**10**	**25**	**15**	**30**	**5**	**15**
POST	**Mean = 5.289 SD = 0.652**	**freq**	**-**	**-**	**-**	**2**	**10**	**7**
	N = 19	**%**	**-**	**-**	**-**	**10**	**53**	**37**

PRE-POST Comparison

Diff = 1.237 SD of diff = 1.358 $t = 3.971$ $df = 18$ $p < .001$

5. Measures needed for pre- and in-service preparation for safe, legal implementation of IDEA in my state.

			1	2	3	4	5	6
PRE	**Mean = 3.925 SD = 1.541**	**freq**	**1**	**4**	**3**	**2**	**7**	**1**
	N = 20	**%**	**5**	**20**	**15**	**10**	**35**	**5**
POST	**Mean = 5.237 SD = 0.752**	**freq**	**-**	**-**	**-**	**4**	**7**	**8**
	N = 19	**%**	**-**	**-**	**-**	**21**	**37**	**42**

PRE-POST Comparison

Diff = 1.395 SD of diff = 1.254 $t = 4.849$ $df = 18$ $p < .000$

6. Resources available to assist pre- and in-service training regarding invasive health care procedures.

			1	2	3	4	5	6
PRE	**Mean = 3.650 SD = 1.470**	**freq**	**2**	**3**	**4**	**5**	**4**	**2**
	N = 20	**%**	**10**	**15**	**20**	**25**	**20**	**10**
POST	**Mean = 5.000 SD = 0.976**	**freq**	**-**	**-**	**2**	**3**	**7**	**7**
	N = 19	**%**	**-**	**-**	**10**	**16**	**37**	**37**

PRE-POST Comparison

Diff = 1.386 SD of diff = 1.268 $t = 4.706$ $df = 18$ $p < .000$

unaware *aware*

7. Funding implications of safe, legal implementation of IDEA in my state.

PRE Mean = 3.600 SD = 1.353
N = 20
POST Mean = 4.500 SD = 1.014
N = 19

		1	2	3	4	5	6
PRE	**freq**	**2**	**1**	**7**	**4**	**5**	**1**
	%	**10**	**5**	**35**	**20**	**25**	**5**
POST	**freq**	**-**	**1**	**2**	**5**	**9**	**2**
	%	**-**	**5**	**10**	**26**	**47**	**10**

PRE-POST Comparison
Diff = 0.868 SD of diff = 1.508 **t = 2.511 df = 18 p < .022**

8. Agency liability issues relating to safe, legal implementation of IDEA.

PRE Mean = 3.725 SD = 1.371
N = 20
POST Mean = 4.816 SD = 0.837
N = 19

		1	2	3	4	5	6
PRE	**freq**	**1**	**2**	**7**	**5**	**2**	**3**
	%	**5**	**10**	**35**	**25**	**10**	**15**
POST	**freq**	**-**	**-**	**2**	**3**	**11**	**3**
	%	**-**	**-**	**10**	**16**	**58**	**16**

PRE-POST Comparison
Diff = 1.053 SD of diff = 1.141 **t = 4.020 df = 18 p < .001**

9. Individual liability issues relating to safe, legal implementation of IDEA.

PRE Mean = 3.950 SD = 1.504
N = 20
POST Mean = 5.237 SD = 0.832
N = 19

		1	2	3	4	5	6
PRE	**freq**	**2**	**2**	**1**	**8**	**4**	**3**
	%	**10**	**10**	**5**	**40**	**20**	**15**
POST	**freq**	**-**	**-**	**1**	**2**	**8**	**8**
	%	**-**	**-**	**5**	**10**	**42**	**42**

PRE-POST Comparison
Diff = 1.342 SD of diff = 1.510 **t = 3.875 df = 18 p < .001**

10. Actions that can promote systems change to achieve safe and legal implementation of IDEA in my state.

PRE Mean = 3.700 SD = 1.525
N = 20
POST Mean = 4.947 SD = 0.621
N = 19

		1	2	3	4	5	6
PRE	**freq**	**3**	**2**	**1**	**7**	**6**	**1**
	%	**15**	**10**	**5**	**35**	**30**	**5**
POST	**freq**	**-**	**-**	**-**	**4**	**12**	**3**
	%	**-**	**-**	**-**	**21**	**63**	**16**

PRE-POST Comparison
Diff = 1.316 SD of diff = 1.336 **t = 4.294 df = 18 p < .000**

11. Actions that can influence policy to achieve safe and legal implementation of IDEA in my state.

				unaware 1	2	3	4	5	aware 6
PRE	**Mean = 3.500**	**SD = 1.395**	**freq**	**2**	**4**	**2**	**6**	**6**	**-**
	N = 20		**%**	**10**	**20**	**10**	**30**	**30**	**-**
POST	**Mean = 4.816**	**SD = 0.901**	**freq**	**-**	**-**	**2**	**4**	**9**	**4**
	N = 19		**%**	**-**	**-**	**10**	**21**	**47**	**21**

PRE-POST Comparison

Diff = 1.395 SD of diff = 1.276 t = 4.766 df = 18 p < .000

12. Changes expected for children with special Health Care Needs under reauthorization of IDEA

				1	2	3	4	5	6
PRE	**Mean = 3.400**	**SD = 1.353**	**freq**	**2**	**3**	**5**	**6**	**3**	**1**
	N = 20		**%**	**10**	**15**	**25**	**30**	**15**	**5**
POST	**Mean = 4.868**	**SD = 0.814**	**freq**	**-**	**-**	**1**	**5**	**9**	**4**
	N = 19		**%**	**-**	**-**	**5**	**26**	**47**	**21**

PRE-POST Comparison

Diff = 1.500 SD of diff = 1.041 t = 6.282 df = 18 p < .000

13. The concerns of classroom educators in meeting the needs of children with special health care needs.

				1	2	3	4	5	6
PRE	**Mean = 4.925**	**SD = 1.173**	**freq**	**1**	**-**	**-**	**4**	**9**	**6**
	N = 20		**%**	**5**	**-**	**-**	**20**	**45**	**30**
POST	**Mean = 5.342**	**SD = 0.625**	**freq**	**-**	**-**	**-**	**2**	**9**	**8**
	N = 19		**%**	**-**	**-**	**-**	**10**	**47**	**42**

PRE-POST Comparison

Diff = 0.447 SD of diff = 0.926 t = 2.105 df = 18 p < .050

14. The status of Medicaid for children with special health care needs.

				1	2	3	4	5	6
PRE	**Mean = 4.300**	**SD = 1.418**	**freq**	**1**	**1**	**3**	**6**	**4**	**5**
	N = 20		**%**	**5**	**5**	**15**	**30**	**20**	**25**
POST	**Mean = 5.079**	**SD = 0.786**	**freq**	**-**	**-**	**1**	**3**	**9**	**6**
	N = 19		**%**	**-**	**-**	**5**	**16**	**47**	**32**

PRE-POST Comparison

Diff = 0.763 SD of diff = 1.358 t = 2.450 df = 18 p < .025

Using the scale below, please rate your confidence in your ability to effect item 15:

1 = completely unsure *3 = slightly unsure* *5 = somewhat confident*
2 = somewhat unsure *4 = slightly confident* *6 = completely confident*

15. Contribute to safe, legal implementation of IDEA in my state.

PRE Mean = 3.579 SD = 1.644
N = 19 (missing =1)
POST Mean = 5.059 SD = 0.982
N = 17

		unsure			*confident*		
		1	2	3	4	5	6
PRE	freq	2	4	4	1	6	2
	%	10	21	21	5	32	10
POST	freq	-	-	2	2	7	6
	%	-	-	12	12	41	35

PRE-POST Comparison
Diff = 1.588 SD of diff = 1.049 t = 6.241 df = 16 p < .000

16. *PRE:* What is(are) the major obstacle(s) to safe, legal implementation of IDEA in your state?
POST: Has the conference helped you identify obstacle(s) to safe, legal implementation of IDEA in your state that you had not considered previously? (If "yes", please note them.)

No.

1 *Pre:* **School district administrators and funding. Lack of school nurses and poor support by administrators. Wait for lawsuit rather than really proactive.**
Post: **Ways to approach administration, day/childcare facilities/providers to offer some resources**

2 *Pre:* **Stumbling blocks are at the highest level in each school district, i.e., superintendent and some building principals. Apprehension and fear on the part of the educators. (The state will inservice them on almost anything but positive inclusion and IDEA implementation. Nurse delegation regulations.**
Post: **Basically delegation as it relates to paraprofessionals in the school setting.**

3 *Pre:* **$$s**
Post: **All the groups that are involved.**

4 *Pre:* **Information dispensation. Provider awareness of nurse practice act, i.e., nurses and MDs.**
Post: **Yes, parent experiences - specifically child care needs. Collaborating disciplines point of views and practice parameters.**

5 *Pre:* **School administrators, lack of funding for professional school nursing services.**
Post: **Yes, alerted to daycare issues.**

6 *Pre:* **Lack of information**
Post: **Yes, need to do more thorough training of paraprofessionals.**

7 *Pre:* **no comment**
Post: **I have no experience with the regulations on child care, either 0-3 or after school. Except to know that many of the children with special needs have been poorly served.**

8 *Pre:* no comment
Post: Yes

9 *Pre:* Money
Post: Yes, attitudes and the lack of education of the law.

10 *Pre:* School district personnel lack of training, knowledge, confidence, funding, etc.- mainly in rural communities. "Yes- buts..."
Post: Yes, delegation, state statues -- I need to research more!

11 *Pre:* Funding limitations for school nurse positions. Teachers concerned about their lack of preparation in managing the health care needs of children with special needs.
Post: no comment

12 *Pre:* Funding to allow nurses to delegate tasks to child care providers.
Post: Yes, practice acts of related professions (PT, OT, etc.).

13 *Pre:* Lack of knowledge among school administrators and communities.
Post: no comment

14 *Pre:* Lack of knowledge related to need for legislative support, decrease in funding, and decrease in population.
Post: Yes, at least to identify what we need in our state.

15 *Pre:* Fear: on the part of the administrative, educational and health care staff
Post: I was pretty clear on this idea prior to this conference.

16 *Pre:* Confusion re: what supervision/delegation entails; Who gets to decide about delegation--Institution or individual? Transportation (schools) takes $.
Post: no comment

17 *Pre:* no comment
Post: no comment

18 *Pre:* Not enough school nurses/community nurses, inadequate knowledge, little or no support for providers.
Post: Yes

19 *Pre:* Who pays for the inservice/training? Who does the training?
Post: Yes, woke me up to understand what the RN has to do to protect her license.

20 *Pre:* **More from the national perspective: some states need changes and need understanding of delegation from the NPA and/or RR delegation to the delegates. Nurses need to be educated on how to delegate. Delegates need to be taught how to be delegated to.**

Post: **no comment**

17. *PRE:* What resources/strategies are already in place in your state for safe, legal implementation of IDEA?

POST: Has the conference helped you identify resources/strategies already in place in your state for safe, legal implementation of IDEA that you had not considered previously?

No.

1 *Pre:* **Knowledge of school nurse--available videos and professional resources. Well-informed teachers both Special Education and regular Education generally.**

Post: **First Start**
Resources for childcare
Other state resources- networking

2 *Pre:* **As for us, I know each District uses their own teams as needed for transition to inclusion from a special school setting. This team usually includes the District Special Ed. Coordinator, parent and support staff and ed. staff from both schools to meet several times.**

Post: **Yes, nurse practice act info., which is clearly defined.**

3 *Pre:* **School districts are having contract nurses for "preschool handicapped classrooms" do to special procedures. On-going dialogue between nursing and Public School Superintendent.**

Post: **More aware of some of the resources and have increased knowledge of strategies.**

4 *Pre:* **no comment**

Post: **Yes, the First Start specifically. The seminars documents will provide excellent reference points in my future thinking and planning around special needs children/students.**

5 *Pre:* **New *document* on providing Health Related Services written by multidisciplinary ad hoc {illegible term, possibly "committee"} for promulgation by NDOE{Nebraska Department of Education}/Special Education.**

Post: **Yes, OTC (medications).**

6 *Pre:* **no comment**

Post: **Yes, additional members for our specified task force.**

7 *Pre:* **no comment**

Post: **We need to look at delegation in our state. I believe there is some wording in the NPA that needs changing.**

8 *Pre:* **no comment**

Post: **Yes**

9 *Pre:* **no comment**
Post: **No**

10 *Pre:* **Part H program - interagency collaboration, District school nurses, LPN's, collaboration with Dept. of Health, Comprehensive Health at State Dept. of Education.**
Multiple Disability/Other Health Impairment- Registry trainings.
Delegation.
Medicaid - schools accessing Medicaid for related services.
Post: **Yes, nursing practice act--helpful will continue to look into regulations received lots of resources!**

11 *Pre:* **Board of Nursing drafting delegatory clause which is based on "Guidelines for Delegations of School Health Services to Unlicensed Assistive Personnel" by the Dept. of Health.**
Post: **Yes, involvement in State Board of Nursing and State Association of School Nursing. Use of NEC*TAS and networking with others concerned with similar issues.**
12 *Pre:* **UCHSC School of Nursing.**
As a result of 1994 Policy Practice Conference - interagency task force on Rx in schools and Child care, with representation of following stakeholders: School nurses, Board of Nursing, CO Health Dept., Child Care Licensing, Child Care Resource and Referral, Public School Risk Management, School District Attorney.
Post: **Will get back to you on this--brain dead now.**

13 *Pre:* **RN's.**
Delegation to Paras.
Inclusion.
Therapies in Schools.
IEP's.
Post: **Helped to outline and define CO NPA.**

14 *Pre:* **1) We have a strong the ARC;**
2) We do have Inclusion programs set up for 3-5 yrs at my agency and we do home visits for 0-3;
3) We also have Medicaid waivers which may provide assistance with in-school aid.
Post: **Yes, at this time I now have a better idea of what the Nurse Practice Act has regarding delegation--and who to begin contracting to find out about policy and other regulations.**

15 *Pre:* **Delegatory Clause in nurse practice act. State level consultant for school nurses.**
Post: **Yes, but of more value was learning resources on a national level, as well as what is happening in other states.**

16 *Pre:* **Delegation exists.**
DDRC and other Community Centers Boards
Post: **no comment**

17 *Pre:* **no comment**
Post: **no comment**

18 *Pre:* Nurse Practice Act
5th year & Part H
Personnel prep.
Parent support and strong parent advocacy
Post: Yes

19 *Pre:* no comment
Post: Yes, I would like to have a meeting between the paraprofessionals, teacher and RN.

20 *Pre:* no comment
Post: no comment

Appendix C

Overall Conference Evaluation

OVERALL CONFERENCE EVALUATION

June 14-15, 1996

Listed below in bold type beneath each question is a statistical summary of the responses provided by 18 of the 20 participants who returned evaluation packets (two respondents did not complete the Overall Conference Assessment). For each rated statement the frequency (freq.) of response in each category, the percentage of respondents (%) selecting each alternative, the mean score for the item (M), the standard deviation (SD), and the number of respondents who left the item unanswered (missing) are presented. Open-ended comments are presented verbatim.

Instructions: *Considering the conference as a whole, please circle the number that best expresses your opinion about the following statements using the six-point scale below:*

1 = strongly disagree *3 = slightly disagree* *5 = moderately agree*
2 = moderately disagree *4 = slightly agree* *6 = strongly agree*

disagree *agree*

1. The overall quality of the speakers was excellent.

		1	2	3	4	5	6
M = 5.722 SD = 0.461	**freq**	-	-	-	-	**5**	**13**
missing = 1	**%**	-	-	-	-	**28**	**72**

2. The educational value of the conference was excellent.

		1	2	3	4	5	6
M = 5.611 SD = 0.608	**freq**	-	-	-	**1**	**5**	**12**
missing = 1	**%**	-	-	-	**6**	**28**	**67**

3. Sufficient time was allotted for the conference.

		1	2	3	4	5	6
M = 4.667 SD = 1.372	**freq**	-	**2**	**2**	**2**	**6**	**6**
missing = 1	**%**	-	**11**	**11**	**11**	**33**	**33**

4. The conference format was very effective.

		1	2	3	4	5	6
M = 5.389 SD = 0.698	**freq**	-	-	-	**2**	**7**	**9**
missing = 1	**%**	-	-	-	**11**	**39**	**50**

5. The objectives for this conference were clear.

		1	2	3	4	5	6
M = 5.389 SD = 0.698	**freq**	-	-	-	**2**	**7**	**9**
missing = 1	**%**	-	-	-	**11**	**39**	**50**

6. The conference met its objectives.

		1	2	3	4	5	6
M = 5.278 SD = 0.826	**freq**	-	-	-	**4**	**5**	**9**
missing = 1	**%**	-	-	-	**22**	**28**	**50**

7. The conference provided a needed forum to interact with other concerned individuals from across the country about issues surrounding the safe, legal implementation of IDEA.

		disagree					*agree*
		1	2	3	4	5	6
M = 5.500 SD = 0.632	**freq**	-	-	-	1	6	9
missing = 3	**%**	-	-	-	6	38	56

Please use the following scale to answer Questions 9 (a & b) & 10:

1 = not at all *3 = a little* *5 = considerably*
2 = very little *4 = moderately* *6 = greatly*

8. Did the parent presentations in this conference heighten your awareness of:

a. How parents of children with special needs would like to be treated by professionals

		not at all					*greatly*
		1	2	3	4	5	6
M = 5.529 SD = 0.624	**freq**	-	-	-	1	6	10
missing = 2	**%**	-	-	-	66	35	59

b. How parents' experiences with their children's gains and losses may impact interactions with professionals

		1	2	3	4	5	6
M = 5.529 SD = 0.624	**freq**	-	-	-	1	6	10
missing = 2	**%**	-	-	-	6	35	59

9. Did the conference heighten your awareness of the viewpoints of allied health professionals (e.g., OTs, RTs) on issues of performance and delegation of invasive health care procedures?

		1	2	3	4	5	6
M = 5.000 SD = 0.935	**freq**	-	-	1	4	6	6
missing = 2	**%**	-	-	6	24	35	35

10. Which aspects of the conference did you find most useful?

No.	
1	**no comment**
2	**Networking time**
3	**Meeting persons form around the country**
4	**no comment**
5	**Variety of experts, legal contributions**
6	**All of it**
7	**no comment**
8	**Delegation**

No.	
9	**Delegation issues- but how do we facilitate change amongst ourselves? (if nurses who won't grow and move forward)**
10	**Delegation discussion**
11	**Solutions in delegation**
12	**CC law center**
13	**no comment**
14	**All, I was really "in the dark" and now I'm am enlightened.**
15	**Networking, exchange ideas and experiences across disciplines and states**
16	**Concerns with delegation**
17	**no comment**
18	**Very excellent mix of speakers and participants, excellent speakers**
19	**no comment**
20	**no comment**

11. Which aspects of the conference did you find least useful?

No.	
1	**no comment**
2	**As I attended not as a nurse but parent and educator I received more than enough knowledge on the legal aspect of delegation.**
3	**Full, Full, Full schedule--but I got tired! But thanks!**
4	**no comment**
5	**Not enough time, for speakers/ questions**
6	**no comment**
7	**no comment**
8	**The first day. It wasn't practice information that can help in my job--second day was much better.**
9	**no comment**
10	**Managed care information/ insurance**
11	**Change agent info.--not new for me**
12	**Arkansas experience**
13	**no comment**
14	**I can't think of anything not useful**
15	**All good information. Very frustrating to consistently be up against time constraints, having time limit cut off presentations.**
16	**Too many speakers on each subject. Too rushed, A true panel might have been better.**
17	**no comment**
18	**Too short**
19	**no comment**
20	**no comment**

12. Were the presentations at a level that met your needs? (17) Yes (-) No

Missing = 2 **100% -**

Please explain:

No.

1 **Yes, not so simple- we had a good basis to start**

2 **Yes, I wish we had time after each presenter to ask questions. (Language was easy for all to understand.)**

3 **Yes, personal experiences and how they did it, helps!**

4 **Yes**

5 **Yes, excellent!**

6 **Yes**

7 **Yes**

8 **Yes and no, you assumed we knew what the details of IDEA, delegation, and ADA , etc., were.**

9 **Yes**

10 **Yes, however, would have liked to see more information regarding implementing practices in the LRE under IDEA. Ideally--an educator providing services in the L.R.E., not in a restrictive setting.**

11 **Yes**

12 **Yes**

13 **Yes**

14 **Yes**

15 **Yes**

16 **Yes, overall--it started at a more than basic level. Sometimes there was a lack of definition of terms.**

17 **no comment**

18 **Generally- some were too elementary.**

19 **Yes**

20 **no comment**

13. If you will pursue a goal related to the issues raised in this conference, please describe your goal and expected actions.

No.

1 **no comment**

2 **Inclusion in LRE for spec. health care needs as they choose to do so. I will be continually working to maintain this level for my daughter through positive communication with the school and knowledge of the law.**

3 See what daycare -- and other reg. in state say about special needs kids

4 no comment

5 Delegation, education of educators, education of nurse delegates No.

6 no comment

7 No specific goal at present. I know I'll be expected to share a lot of this with various groups. From that I'm sure something will develop

8 To become a better child advocate and not let administration intimidate you to back down

9 no comment

10 Implementing practices for children with special health care needs in the Least Restrictive Environment (LRE). This would involve procedures for children with needs for G-tubes, suctioning, ventilation, DNRs, etc. a) research state delegation policy further; b) look for existing statues, practices, etc;c) identify needs, specific areas to be addressed (rural/urban); d) address needs by becoming more knowledgeable to provide technical assistance; e) develop resources for schools; f) spotlight schools implementing practices in the LRE (We have lots of children in regular classrooms with these needs.); and, g) share successes and promising practices.

11 Training for paraprofessionals (foster parents) in caring for children with special needs. Curriculum development with an Interdisciplinary focus

12 Will get back to you on this 290-9088

13 Write a paper in Ecology of Care on medication administration by child care providers and delegation by nurses--create policy?

14 My goal will be to write and place policies/procedures for delegating in our work setting to provide safe and effective care

15 no comment

16 no comment

17 no comment

18 I will continue to promote inclusive services

19 I would like to improve communication between paraprofessionals and RNs. I would like to see current health care plans are up to date.

20 no comment

14. Do you have any other comments or suggestions about the conference?

No.

1 no comment

2 I was, from a teacher and parent point of view, expecting more actual ideas and guidelines for medical inclusions of special health care children under IDEA-- We received many different ideas and a view of the law but not what I had anticipated in hands on inclusion guidelines to share with my state and begin to use on Monday! Perhaps this was due to my interpretation of your conference pamphlet.

3 Need more people here to lead the discussions

4 no comment

5 Longer time provided for presenters and questions

6 no comment
7 no comment
8 Copies of IDEA, delegation and ADA
9 no comment
10 Look at exemplary programs, serving students in LRE.So many Colorado issues- programs what about other states! Pharmacology issues, dietary needs. What about the statewide systems change grants looking at LRE for severely disabled children
11 no comment
12 Superb logistics
13 no comment
14 no comment
15 Allot more time for questions, answers and discussions
16 See 11
17 no comment
18 Get the project funded
19 Thank you for a wonderful conference
20 no comment

APPENDICE G

Evaluations Year 02 & 03

SECOND NATIONAL CONFERENCE ON DEVELOPING POLICY AND PRACTICE TO IMPLEMENT THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT RELATED TO INVASIVE HEALTH CARE PROCEDURES FOR YOUNG CHILDREN

June 16 - 17, 1995

CONFERENCE EVALUATION REPORT

Prepared by Geraldine Steinke, PhD
May, 1996

University of Colorado Health Sciences Center
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Executive Summary

June 16 - 17, 1995, in Denver, Colorado, the second national Conference on Developing Policy and Practice was held. The multi-disciplinary forum addressed issues impacting the safe and legal implementation of the Individuals with Disabilities Education Act (IDEA) for young children who require invasive health care procedures. Conference goal attainment was assessed through a comprehensive objectives-driven evaluation.

Evaluation objectives. Four evaluation objectives were defined as follows:

1. Determination of the effectiveness of efforts to attract a multisate, interdisciplinary audience.

2. Determination of effectiveness in raising awareness of issues pertaining to inclusion and invasive procedures and raising confidence in ability to impact inclusion.

3. Determination of the quality of the conference overall and of its constituent elements.

4. Determination of effectiveness in focusing participants' concerns regarding safe and legal implementation of IDEA related to invasive procedures for children with special health care needs.

Method. Five instruments were designed to address the evaluation objectives:

a) The Participant Information Sheet - a descriptive and demographic questionnaire (completed at the start of the conference) examining efforts to attract an interdisciplinary audience (Objective 1).

b) The Pre- and Post-Conference Self Assessments - a Likert-style repeated measure (completed at the start and conclusion of the conference) of awareness of the focal areas addressed in the conference and of confidence in ability to impact implementation of IDEA, including open-ended identification of obstacles and assets in implementation, employed to establish baseline awareness and detect conference impact on focal issues (Objective 2).

c) The Session Rating Form - a Likert-style rating form to assess the quality, depth, and usefulness of each presentation or session, employed to assess the quality of conference elements (part of Objective 3).

d) The Overall Conference Evaluation - a 14 item questionnaire completed at the conclusion of the conference, including Likert-style rated items about the overall quality of the conference and open-ended questions, employed to assess the conference in its entirety (part of Objective 3).

e) The Participant Action Plan - a format for defining relevant problem areas, goals and strategies (completed at the end of the conference), employed to focus participant concerns and skills regarding safe and legal implementation of IDEA related to invasive procedures (Objective 4).

All five instruments were included in an Evaluation Packet distributed to attendees at registration and collected at the conclusion of the conference. Numerical data (ratings and frequencies) were analyzed to yield descriptive statistics and, for the Pre- and Post-Conference Self-Assessments, repeated measures t-tests were computed to provide inferential statistics. Open-ended responses were coded for thematic content.

Results. Of 30 registered participants, 23 (77%) returned substantially complete packets. The lowest completion rate was observed for the Action Plan (12 respondents submitted plans, including one shared plan).

a) Participant Information Sheet. Registrants represented 17 states, with speakers from two additional states and the District of Columbia[1]. Respondents to evaluation forms were white (100%) and predominantly female (96%), with the modal education at the at the masters' degree level (48%). Nursing was the most frequently noted profession (65%), although sometimes in combination with degrees in other fields. Education, social work, administration (at the state level), psychology, and speech/language pathology were among other professions represented, as were parents of children with special needs.

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[1] Together, the first and second conferences attracted a total of 27 states, and the District of Columbia.

b) Pre- and Post-Conference Self Assessments. Post- ratings were significantly higher than Pre- ratings for 12 of 14 items ($p < .05$ or better), while one item approached significance ($p < .08$). At both the pre- and post-tests, respondents felt least aware of the funding implications of IDEA. Major obstacles to implementation included: funding, inadequate staffing of school nurses, lack of awareness or knowledge, and problematic statutes. Assets to implementation were highly variable from one state to another including, for example: state level plans, programs in place, supportive laws, and expertise at the state or district level.

c) Session Rating Form. All presentations/sessions received positive ratings. Extremely high correlations among ratings of quality, depth, and usefulness indicated a single dimension was being evaluated, interpreted to represent the overall satisfaction with the presentation. A composite score was therefore computed for each session/presentation that was the arithmetic mean of the scores for the three dimensions. Inspection of the composite means revealed that 16 of the 21 ratings achieved scores above 5 (on the six point scale). Participants preferred sessions regarding the status of applicable laws, the outlook for federal funding and national policy, and experiences of the children and their parents. Strategies, resources, and models were also highly rated.

d) Overall Conference Evaluation. Very high mean ratings were attained for all rated items, ranging from 5.59 (for overall quality of speakers) to 5.09 (for adequacy of time allotted) on a six point scale. Most valued aspects included the report of the status of the law and legal ramifications, parents sharing their experiences, the status of and statistics regarding children with special needs, and the materials provided in conference notebooks. Criticisms of the conference were few (as indicated in responses to the "least useful" item). Among those who did comment, there was little consensus regarding least useful aspects although presentations on managed care and changing payer/provider markets were noted two to three times. Providing a longer conference and increasing opportunities for exchange between registrants were the most frequently suggested improvements.

e) Participant Action Plans. Although the sophistication of the plans varied widely, most participants had clearly identified concerns including: advocacy on behalf of the children and their families, inadequacy of statewide policies statewide for meeting special health care needs in schools, inadequate supervision of health related services in child care, failure to provide health related services in schools, personnel preparation issues and interdisciplinary role ambiguity in delivery of services. To address problems in these areas, goals were identified that impacted: availability of nursing resources, statewide policy creation/revision and implementation of change, training providers of invasive procedures, the approach to service delivery, and communication/information dissemination. Strategies included: task force/coalition building, research, education, information dissemination, and lobbying.

Summary and Recommendations. (Organized by objective)

Objective 1. The results of the Participant Information Sheet indicated reasonable success in attracting geographic and interdisciplinary diversity.

It is recommended that:

1. Efforts to contact the remaining unrepresented states should be intensified.
2. Since physician and educator participation was low, these professions should be targeted for dissemination of the *Proceedings* of these conferences.
3. Use of electronic media and forums reaching diverse professions should be strengthened for dissemination of conference announcements.

Objective 2. Comparison of the Pre- and Post-Conference Self Assessments indicated substantial success in increasing awareness of focal conference issues and increasing participant confidence in abilities to impact safe and legal implementation of IDEA related to invasive procedures. Funding implications of implementation present the greatest challenge both pre- and post-conference.

It is recommended that:

1. Despite a significant increase in participant's awareness of the funding implications of implementation of IDEA relative to invasive procedures, its ranking as the lowest rated item (at both the pre- and post- ratings) and frequent citation as a major obstacle to safe and legal implementation of IDEA related to invasive procedures indicates that funding is an issue meriting more attention in the final conference.

2. Participants' comments identifying the need for more information, especially regarding resources (technical and funding), safety and liability issues, and the specific health needs of the children re-affirm the importance of dissemination of the conference proceedings and ongoing coverage of these issues in the final conference.

Objective 3. The results of the Session Rating Form and Overall Conference Evaluation revealed positive or highly positive participant evaluations of the conference and its component elements.

On the basis of data obtained from these instruments, it is recommended that:

1. Utilize small group interactions to increase exchange between participants and networking opportunities and to relieve the intensity of the program.
2. Offer more models and strategies in place in other states.
3. Strengthen educator input in the program.

Objective 4. As demonstrated in Action Plans, by the close of the conference, most participants had focused their concerns regarding safe and legal implementation of IDEA related to invasive procedures for children with special health care needs.

It is recommended that:

1. More models of successful or in-progress programs should be presented;

2. Parent involvement in presentations should be increased;

3. More detailed information on successful strategies of change agents should be emphasized; and,

4. The roles of various professions in collaborating on these issues should be more thoroughly explored in the final conference.

Conclusion. The second Policy and Practice Conference successfully fulfilled its major objectives of providing a high quality forum and increasing awareness and confidence regarding safe and legal implementation of IDEA related to invasive procedures for children with special health care needs. Conference evaluations suggest that participants were energized to take action on these issues by the conclusion of the conference. Attraction of a national, audience of diverse composition was more modestly attained, although cumulatively, the first and second conferences drew representation from 27 states and the District of Columbia. Finally, the feedback participants provided on the evaluation instruments was used to formulate recommendations for the third and final conference in this series.

Acknowledgements

The author thankfully acknowledges the contributions of Drs. Carolie Coates, Don Soltz, Sandy Larson, and Wendy Nehring for consultation in evaluation planning and instrument design for the first National Conference, which served as the model for the plan used in the Second Conference.

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Table 1. Pre- and Post- Conference Assessments

Table 2. Session Rating Form

Table 3. Overall Conference Evaluation

The Second National Conference on Developing Policy and Practice for the Implementation of the Individuals with Disabilities Education Act (IDEA) related to Invasive Health Care Procedures for Young Children was held June 16 -17, 1995, in Denver, Colorado. The conference provided a national, interdisciplinary forum for a multi-faceted exploration of issues such as the status and needs of the children, the legality and process of delegation to unlicensed assistive personnel under Nurse Practice Acts, and resources (e.g., information, training, and funding resources) that influence inclusion for young children with special health care needs. To provide objective data for assessment of conference goal attainment, a comprehensive evaluation was designed and conducted, modelled after the evaluation employed for the First National Conference. The body of this report describes the Evaluation Plan, the Evaluation Results, and Summary Recommendations.

Evaluation Plan

The evaluation of the Second National Conference was designed to address four specific evaluation objectives, using five instruments devised or modified for this evaluation. The evaluation objectives, associated methods, and instrumentation, as well as the procedures for administration and data analysis, are detailed below.

Evaluation Objectives and Methods

The four evaluation objectives and the accompanying methods for assessing their attainment are described below.

1. To determine the effectiveness of efforts to attract a multistate, interdisciplinary audience, a description was compiled of the participants in terms of selected demographic characteristics, level of education, and nature of occupation.

2. To determine effectiveness in raising awareness of major conference issues, pre- and post-conference levels of awareness of issues pertaining to inclusion and invasive procedures, as well as confidence in ability to impact implementation of IDEA related to invasive procedures, was assessed.

3. To determine the quality of the conference overall and of its constituent elements, participants evaluated the quality, depth and usefulness of presentations, as well as the conference as a whole.

4. To determine effectiveness in focusing participants' concerns, problems areas they expected to influence, their goals, and their strategies were compiled.

Instrumentation and Procedures

To address these objectives, five instruments were administered, one of which was completed as a repeated measure.

a) The **Participant Information Sheet** is a descriptive and demographic questionnaire requesting the participant's name, current position title, work address and telephone number, and, in checklist format, nature of current position, highest level of academic work completed, ethnicity and gender, and means of learning about the conference. The form was completed at the beginning of the conference and provided frequency data (e.g., numbers of administrators).

b) The **Pre- and Post-Conference Self Assessments**, a repeated measure, required ratings of awareness of 13 focal areas addressed in the conference and of confidence in ability to impact IDEA in the home state. Rated items included awareness of: a) state legislation impacting the care of children with special health care needs; b) the status of delegation of nursing tasks in the home state; c) needed amendments to the home state Nurse Practice Act for safe, legal implementation of IDEA; d) resources to assist implementation of IDEA; e) measures needed for pre- and in-service preparation for safe, legal implementation of IDEA; f) resources to assist pre- and in-service training regarding medically invasive procedures; g) funding implications of safe, legal implementation of IDEA; h & i) agency, and individual liability issues relating to safe and legal implementation; j & k) actions that promote systems change, and influence policy to achieve safe and legal implementation; l) the complexity and nature of problems confronted by parents of children with special health care needs; and, m) the importance of cultural competence in service delivery to children with special health care needs and their families; as well as confidence in ability to contribute to IDEA implementation. Items were rated on a six point Likert-style scale ranging from completely unaware to completely aware, or completely unsure to completely confident, dependent upon content. In two open-ended questions, respondents identified major obstacles and progress in implementing IDEA in their home states. The Assessments were completed at the beginning of the conference (Pre-) and again at its conclusion (Post-Conference Self-Assessment). The two sets of ratings were subjected to repeated-measures *t*-tests to detect the impact of the conference. Responses to open-ended questions were coded for thematic content.

c) The **Session Rating Form** assessed the quality, depth, and usefulness of each conference session or presentation, using a six point Likert-style rating scale in which higher numbers were more favorable. Comments were also invited. Participants rated each session at its conclusion. Mean ratings were calculated for each of the three dimensions (quality, depth, and usefulness) for each session or presentation.

d) The **Overall Conference Evaluation** assessed the quality and usefulness of the Conference in a 14 item questionnaire. Nine statements, rated on a six point Likert-style scale, addressed: 1) overall quality of the assembled speakers; 2) educational value of the conference; 3) adequacy of time was allotted for the conference; 4) conference format; 5) clarity of conference objectives; 6) attainment of conference objectives; 7) helpfulness of speakers/staff in assisting action planning; 8) expected usefulness of the personal action plan; and, 9) value of the conference as a forum for interaction. Responses to five open-ended questions identified the most and least useful aspects of the program, commentary on the appropriateness of presentations, and suggestions for future conferences. The data were summarized to provide means for each rated questions, with the open-ended responses coded for thematic content.

e) The **Participant Action Plan** is a format for focusing participant interests and skills in a tangible conference product. The format requires the participant to identify a problem area associated with implementation of IDEA regarding invasive procedures, a related goal applicable to the work setting or sphere of influence/interest, and a brief plan of action (list of strategies) to be implemented within the next six months. Just prior to adjournment of the conference, speakers and staff were available as resources to the participants as they devised their personal action plans. Problem areas, goals and strategies specified in the plans were grouped by thematic content for reporting purposes.

Each participant received an Evaluation Packet that included the instruments described above. The packets were collected at the conclusion of the conference. The data were analyzed to yield descriptive statistics and, for the Pre- and Post-Conference Self-Assessments, inferential statistics (repeated measures *t*-tests).

Evaluation Results

Of the 30 registrants, 23 (77%) returned substantially complete evaluation packets, although there was some variability in the numbers responding to each questionnaire or form. Complete presentations of descriptive and, where applicable, inferential statistics are presented on the questionnaire forms in the Appendices. The results of the evaluation are presented by instrument.

Participant Information Sheet

The Participant Information Sheet is a descriptive and demographic questionnaire, and the first element in the Evaluation Packet for the conference. The form requested the participant's name, current position title, work address and telephone number (if employed). Checklists were also provided to describe the participant's current position, highest level of academic work completed, ethnicity and gender, and means of learning about the conference. (For a data summary of frequencies and percentages see Appendix A.)

Demographics

Respondents were all ethnically white. All but one registered participant was female (96%).

Disciplines/Occupations

Respondents used the checklist of disciplines and occupations to describe the nature of their positions. Although nurses were prevalent (65%), several disciplines and professions were represented. These included: educators (17% of respondents) at various levels including early childhood special education, university level educators in nursing, psychology and special education, and paraprofessional education; social workers and administrators (each at 9%); and one psychologist and one speech/language specialist (each at 4%). Staff of health departments and other state agencies (13%) and parent advocates (9%) accounted for the remainder of respondents. (Note: the total exceeds 100% since some participants endorsed two or more choices, most often nursing and one other item.)

Academic Degrees

The master's degree was the modal educational level (48%), including several masters' in nursing and areas associated with education or child development, as well as singular reports of masters' in social work, speech/language, health education, school psychology, political science, and science. The next most frequently noted degrees RNs (26%), the baccalaureates in nursing (17%), followed by doctoral degrees (9% EdD, 4% PhD), associate degrees (9%) and some non-degree college credit (4%). It should be noted that several respondents reported degrees in two fields.

National Representation

The home addresses of registrants revealed that 17 states were represented by registrants. The states were Colorado, Arkansas, Florida, Alabama, Hawaii, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Missouri, Nebraska, North Dakota, Ohio, West Virginia, and Wisconsin. In addition, speakers represented North Carolina and Maine, as well as the District of Columbia. Cumulatively, the first and second conferences drew participants (registrants and speakers) from a total of 27 states.

Awareness of Conference

Finally, the majority of respondents learned about the conference through distribution of the conference brochure (52%), followed by word-of-mouth (26%), other sources (22%) including the previous conference proceedings, and newsletter announcements, or recommendation from past participants (9%). Electronic mail and Internet listings were not productive.

Section Summary

The Participant Information Sheet and registration information revealed that the respondents were drawn from 17 states and had learned of the conference through the brochure or word-of-mouth. They were primarily white females in positions related to nursing, education, and other diverse fields. Almost all were educated the baccalaureate level or higher (nearly half held masters' degrees).

Pre- and Post-Conference Self-Assessment

The Pre- and Post-Conference Self Assessments required respondents to rate their levels of awareness of issues addressed in the conference and their confidence in their abilities to impact IDEA in their home states. Open-ended comments were sought to elicit the major obstacles and elements already in place in the implementation of IDEA in their home states.

The Self-Assessment was completed as a repeated measure, addressing identical issues in the pre- and post-conference versions. The questionnaire included 13 items on awareness of the issues and one on confidence in effecting changes related to IDEA. Items were rated on a six point scale ranging from completely unaware to completely aware, or completely unsure to completely confident, dependent upon the item. Of the 30 registrants, 23 (76%) completed the Pre-Conference Self-Assessment and all but one completed the Post-Conference form. Table 1. Pre- and Post-Conference Self-Assessments, displays the means of the Pre- and post-assessments, the difference between them (Pre-Post Diff.), standard deviations (SD), t-test value (t), degrees of freedom (df), and probability level (p) for each item in the repeated measure. (See Appendix B for the complete presentation of descriptive and inferential statistics, including frequencies, and verbatim open-ended responses.)

Ratings

In pre-conference ratings, familiarity with "awareness" issues ranked as follows (in descending order of familiarity): a) the importance of cultural competence in service delivery to children with special health care needs and their families (PRE Mean = 4.761, SD = 0.903); home state legislation impacting the care of children with disabilities with special health care needs (PRE Mean = 4.522, SD = 1.344); the status of delegation of nursing tasks in the home state (PRE Mean = 4.522, SD = 1.675); measures needed for pre- and in-service preparation for safe, legal implementation of IDEA in the home state (PRE Mean = 3.870, SD = 1.576); resources available to assist implementation of IDEA in the home state (PRE Mean = 3.826, SD = 1.749); individual liability issues relating to safe, legal implementation of IDEA (PRE Mean = 3.727, SD = 1.316); resources available to assist pre- and in-service training regarding medically invasive procedures (PRE Mean = 3.609, SD = 1.803); needed amendments to the home state's Nurse Practice Act for safe, legal implementation of IDEA (PRE Mean = 3.565, SD = 1.727); agency liability issues

Table 1. PRE- and POST-CONFERENCE SELF-ASSESSMENTS

Respondents rated the statements below using a six point scale (1 = completely unaware to 6 = completely aware)

Statement	Pre Mean (SD)	Post Mean (SD)	Pre-Post Diff. (SD)	t	df	p
My state's legislation impacting the care of children with disabilities with special health care needs.	4.522 (1.344)	5.024 (0.901)	0.452 (1.117)	1.856	20	.078
The status of delegation of nursing tasks in my state.	4.522 (1.675)	5.381 (0.794)	0.714 (1.146)	2.855	20	.010
Needed amendments to my state's Nurse Practice Act for safe, legal implementation of I.D.E.A.	3.565 (1.727)	5.238 (0.625)	1.476 (1.504)	4.498	20	.000
Resources available to assist implementation of I.D.E.A. in my state.	3.826 (1.749)	4.952 (1.024)	1.286 (1.271)	4.637	20	.000
Measures needed for pre- and in-service preparation for safe, legal implementation of I.D.E.A. in my state.	3.870 (1.576)	5.048 (1.024)	1.333 (1.278)	4.781	20	.000
Resources available to assist pre- and in-service training regarding medically invasive procedures.	3.609 (1.803)	5.048 (1.024)	1.333 (1.390)	4.394	20	.000
Funding implications of safe, legal implementation of I.D.E.A. in my state.	3.174 (1.337)	4.762 (1.136)	1.429 (1.165)	5.620	20	.000
Agency liability issues relating to safe, legal implementation of I.D.E.A.	3.409 (1.403)	5.190 (0.981)	1.714 (1.146)	6.852	20	.000
Individual liability issues relating to safe, legal implementation of I.D.E.A.	3.727 (1.316)	5.095 (1.044)	1.333 (1.065)	5.739	20	.000

Table 1. **PRE- and POST-CONFERENCE SELF-ASSESSMENTS** (continued)

Statement	Pre Mean (SD)	Post Mean (SD)	Pre-Post Diff (SD)	t	df	p
Actions that can promote systems change to achieve safe and legal implementation of I.D.E.A. in my state.	3.364 (1.293)	5.000 (0.949)	1.619 (1.359)	5.458	20	.000
Actions that can influence policy to achieve safe and legal implementation of IDEA in my state.	3.341 (1.148)	4.905 (0.831)	1.548 (1.182)	5.999	20	.000
The complexity and nature of problems confronted by parents of children with special health care needs.	5.348 (0.573)	5.381 (0.740)	0.048 (0.805)	0.271	20	.789
The importance of cultural competence in service delivery to children with special health care needs and their families.	4.761 (0.903)	5.429 (0.811)	0.738 (1.221)	2.771	20	.012
Ability to contribute to safe, legal implementation of I.D.E.A. in my state.*	3.810 (1.401)	4.750 (0.786)	0.842 (1.463)	2.509	18	.022

** Respondents rated this item using a six point scale (1 = completely unsure to 6 = completely confident.*

relating to safe, legal implementation of IDEA (PRE Mean = 3.409, SD = 1.403); actions that can promote systems change to achieve safe and legal implementation of IDEA in the home state (PRE Mean = 3.364, SD = 1.293); actions that can influence policy to achieve safe and legal implementation of IDEA in the home state (PRE Mean = 3.341, SD = 1.148); and funding implications of safe, legal implementation of IDEA in the home state (PRE Mean = 3.174, SD = 1.337).

Upon post-conference assessment, all of the awareness ratings identified in the immediately preceding paragraph had improved (as indicated in two-tailed, paired *t*-tests). Reviewing pre-post comparisons of items significant at the .000 level of probability in two-tailed *t* tests, participants left the conference more aware of (in order of magnitude of the pre-post mean differences): a) actions that can promote systems change to achieve safe and legal implementation of IDEA (Diff = 1.619, SD of diff = 1.359); b) actions that can influence policy to achieve safe and legal implementation of IDEA (Diff = 1.548, SD of diff = 1.182); c) needed amendments to their states' Nurse Practice Acts (Diff = 1.476, SD of diff = 1.504); d) funding implications of safe, legal implementation of IDEA in the home state (Diff = 1.429, SD of diff = 1.165); e) measures needed for pre- and in-service preparation for safe, legal implementation of IDEA (Diff = 1.333, SD of diff = 1.278); f) resources to assist pre- and in-service training in invasive procedures (Diff = 1.333, SD of diff = 1.390); g) related individual liability issues (Diff = 1.333, SD of diff = 1.065); h) resources to assist implementation of IDEA (Diff = +1.286, SD of diff = 1.271); and, i) agency liability issues relating to safe, legal implementation of IDEA (Diff = 1.714, SD of diff = 1.146).

Significant pre-post conference differences ($p < .01$) were also obtained for the importance of cultural competence in service delivery (Diff = 0.738, SD of diff = 1.221) and the status of delegation of nursing tasks in the home state (Diff = 0.714, SD of diff = 1.146). Finally pre-post assessment of awareness of the home state legislation impacting the care of children with disabilities with special health care needs tended toward significance (Diff = 0.452, SD = 1.117, $p < .08$).

Open-ended Comments

Two open-ended questions addressed awareness of obstacles and assets to implementation of IDEA in the home states (pre-conference assessment) and whether the conference helped in identification of these factors (post-conference assessment). While three respondents were unaware of the major obstacles to safe, legal implementation of IDEA in their home states, the most frequently cited issues were: funding (11 comments), inadequate staffing of school nurses or nurse/student ratio (five comments), lack of awareness, knowledge and experience with standards and procedures (four comments), and the statutes in place (two comments). Singular comments identified safety issues, multiple sites with children who are medically fragile, poor community involvement at the secondary level in the school district, availability of services, and poor cooperation by the State Department of Education. In addition, two ambiguous comments noted "fear" and "personnel" as obstacles, but the respondents precise meanings could not be discerned. At the post-conference assessment, 14 of 16 individuals responded that the conference had helped them identify issues, while two were uncertain. Heightened awareness of funding issues, of the ramifications of delegation, of statutes, and of the implications of medication policies, government involvement and networking with resource people in other states were all specified. The range of existing resources varied from: state level plans or collaboration, specific departments, councils or programs committed to inclusion; to supportive laws in place (i.e., NPAs); to the expertise of specific individuals in key state or district level positions (e.g., state school nurse consultant), and isolated examples of inclusive programs in already in place.

Although one respondent felt the conference had not helped reveal state level assets to support the implementation of inclusion, the majority of respondents felt that the conference had increased their awareness. Often however, they stated that it was now up to them to discover the specific state-level resources that would aid in goal attainment.

Section Summary

Post- ratings were significantly higher than Pre- ratings for 12 of 14 items, with an additional item approaching significance. At both the pre- and post-tests, respondents felt least aware of funding implications of IDEA. Major obstacles to implementation included: funding, inadequate staffing of school nurses, lack of awareness or knowledge, and problematic statutes. Assets to implementation were highly variable from one state to another including, for example, state level plans, programs in place, supportive laws, and expertise at the state or district level.

Session Rating Form

All 23 of the conference participants who returned evaluation packets completed session ratings for most or all of the sessions. All presentations were rated for quality, depth and usefulness on a six point rating scale ranging from 1 (very unfavorable) to 6 (very favorable). Table 2, Session Rating Form, presents the item mean (M), standard deviation

(SD), and number of respondents rating the session (N) all three dimensions for each presentation or session.

Ratings

While each presentation was rated for quality, depth, and usefulness, Pearson correlation coefficients between the dimensions were so high ($r > .95$) as to indicate that one fundamental dimension was being rated. Therefore, a composite mean rating (the arithmetic mean of the three dimensions) was computed, interpreted as reflecting general satisfaction with the presentation. Each component variable correlated .98 with the composite variable, so that the composite mean will be discussed to examine satisfaction with the presentations.

No presentation received a mean rating below 4 (slightly favorable), and most were above 5 (favorable). In order of satisfaction (as expressed in the composite mean), the presentations ranked in the following order: Status of the Law (Long), Children's Stories (Johnson), Day 2 Luncheon Address (Schroeder), SSI (Nackashi), Personal Experiences (Edwards & Rosenberg), all of which were rated 5.5 or higher (very favorable); Lobbying 101 (O'Neal), Consulting Model (Perreault), Information Network (Shackelford), Risks and Consequences (Long and Phillips), Status of Delegation (Nay), Statewide Survey (Hertel & Swigert), Project ASSIST (Uris), Carin' Clinic (Connor), Managed Care (Jones), Establishing Policy (L. Siderius), and Cultural Competence (Nackashi), all of which received composite ratings of 5 to 5.49. In addition, four of the five remaining sessions had mean

Table 2. SESSION RATING FORM

Respondents used the following 6 point scale to rate the a) overall quality, b) usefulness of information, and c) appropriateness of depth of each presentation.

1 = very unfavorable	3 = slightly unfavorable	5 = favorable
2 = unfavorable	4 = slightly favorable	6 = very favorable

Speaker(s)/ Topic Key Words	*Statistic*	*Quality*	*Usefulness*	*Depth*
M. Culkin	*Mean*	**4.870**	**4.348**	**4.739**
Quality and Safety	*SD*	**0.920**	**1.229**	**0.864**
	N	**23**	**23**	**23**
T. Johnson	*Mean*	**5.727**	**5.591**	**5.636**
The Children's Stories	*SD*	**0.456**	**0.590**	**0.492**
	N	**22**	**22**	**22**
M. Long	*Mean*	**5.652**	**5.652**	**5.652**
Status of the Law	*SD*	**0.487**	**0.487**	**0.487**
	N	**23**	**23**	**23**
D. Nay	*Mean*	**5.304**	**5.435**	**5.348**
Status of Delegation	*SD*	**0.765**	**0.728**	**0.714**
	N	**23**	**23**	**23**
P. Motz & R. Fordyce	*Mean*	**4.818**	**4.773**	**4.727**
Inservice Video	*SD*	**0.907**	**0.685**	**0.767**
	N	**22**	**22**	**22**
J. Nackashi	*Mean*	**5.227**	**5.045**	**4.773**
Cultural Competence	*SD*	**1.066**	**1.133**	**1.412**
	N	**22**	**22**	**22**
J. Edwards & B. Rosenberg	*Mean*	**5.500**	**5.545**	**5.545**
Personal Experiences	*SD*	**0.802**	**0.653**	**0.653**
	N	**22**	**22**	**22**
D. Stockford	*Mean*	**4.700**	**4.650**	**4.600**
National & State Initiatives	*SD*	**1.031**	**1.040**	**1.095**
	N	**20**	**20**	**20**
D. O'Neal	*Mean*	**5.476**	**5.476**	**5.429**
Lobbying 101	*SD*	**0.602**	**0.602**	**0.676**
	N	**21**	**21**	**21**
K. Connor	*Mean*	**5.190**	**5.190**	**5.143**
Carin' Clinic	*SD*	**0.814**	**0.814**	**0.854**
	N	**21**	**21**	**21**

Speaker(s)/ Topic Key Words	*Statistic*	*Quality*	*Usefulness*	*Depth*
V. Hertel & M. Swigert	*Mean*	5.318	5.364	5.227
Statewide Survey	*SD*	0.568	0.581	0.528
	N	22	22	22
M. Long/S. Phillips	*Mean*	5.409	5.409	5.318
Risks and Consequences	*SD*	0.666	0.590	0.646
	N	22	22	22
W. Nehring	*Mean*	5.087	4.870	4.826
Boundaries & Attitudes	*SD*	0.848	1.014	1.029
	N	23	23	23
L. Siderius	*Mean*	5.043	5.000	5.043
Establishing Policy	*SD*	0.976	1.000	0.928
	N	23	23	23
P. Schroeder	*Mean*	5.591	5.609	5.565
Luncheon Address	*SD*	0.666	0.583	0.788
	N	22	23	23
P. Uris	*Mean*	5.278	5.222	5.167
Project ASSIST	*SD*	0.669	0.732	0.786
	N	18	18	18
C. Perreault	*Mean*	5.389	5.556	5.389
Consulting Model	*SD*	0.502	0.511	0.502
	N	18	18	18
J. Shackelford	*Mean*	5.444	5.500	5.389
Information Network	*SD*	0.616	0.514	0.698
	N	18	18	18
J. Carlisle	*Mean*	4.400	4.200	4.400
Payor/Provider Networks	*SD*	0.986	1.146	1.183
	N	15	15	15
P. Jones	*Mean*	5.200	5.067	5.133
Managed Care	*SD*	0.775	0.884	0.915
	N	15	15	15
J. Nackashi	*Mean*	5.533	5.600	5.600
SSI	*SD*	0.640	0.507	0.507
	N	15	15	15

composite ratings above 4.5 approaching "favorable" (the remaining session was a video presentation on evolving payer/providers markets (by Carlisle) rated at 4.4).

Comments

Only two respondents made comments on the Session Rating Form. One criticized having multiple parents present ("One parent experience would have been sufficient"). The same individual also took exception to working lunches. The second set of comments complimented the dedication of the conference team to the issues affecting children with special health care needs.

Section Summary

High correlations between the dimensions rated (quality, depth and usefulness) indicated a single dimension was in fact rated in the Session Rating form. A composite mean was therefore computed to facilitate the discussion of the outcomes indicated in these ratings. Review of the composite scores revealed that 16 of the 21 ratings achieved scores above 5 on the six point scale. None of the sessions were rated unfavorably.

Participants provided the most favorable ratings for sessions describing the current status of the law, the outlook for federal funding and national policy, and the experiences of specific children and their parents. Presentations that provided strategies, resources, and models fell in the middle ground, while video presentations and those addressing the status of child care and national education initiatives were less well received, although still positively rated.

Overall Conference Evaluation

The Overall Conference Evaluation, a 14 item questionnaire, required respondents to provide feedback regarding the quality and usefulness of the Policy and Practice Conference. Nine statements were rated on a six point Likert-style scale ranging from "strongly disagree" to "strongly agree", where higher scores reflected more favorable attitudes. The remaining five questions were open-ended requests for identification of the most and least useful aspects of the program, for commentary on the overall level of presentations, and for suggestions for future conferences. Twenty-two of 23 participants (96%) who returned evaluation packets completed Overall Conference Evaluations (one individual did not complete any post-conference assessments). Table 3 displays Overall Conference Evaluation means for each item.

Rated Items

All of the rated items achieved scores of at least 5.0 on the six point rating scale indicating a high level of satisfaction with the conference. Respondents strongly agreed that the overall quality of the speakers was excellent, with 83% choosing 6, the highest rating (Mean = 5.527, of a possible 6, SD = 0.456). Other highly rated items indicated strong agreement that the educational value of the conference was excellent (Mean = 5.591, SD = 0.503) and the speakers and staff were helpful in action planning (Mean = 5.524, SD = 0.512). The conference was seen as meeting its objectives (Mean = 5.409, SD = 0.590) and providing a needed forum to address implementation of IDEA (Mean = 5.409, SD = 0.734), as well as having clear objectives (Mean = 5.318, SD = 0.646).

While still very favorable, slightly lower ratings were achieved for the usefulness of personal action plans (Mean = 5.296, SD = 0.564), the effectiveness of the conference format (Mean = 5.227, SD = 0.612), and the adequacy of time allotted for the conference (Mean = 5.091, SD = 0.921).

TABLE 3

MEAN RATINGS OF OVERALL CONFERENCE EVALUATION ITEMS

Items were rated on a six point Likert-style scale where 1 = strongly disagree, and 6 = strongly agree.

	Mean		SD
The overall quality of the speakers was excellent.	5.527		0.456
The educational value of the conference was excellent.	5.591		0.503
Sufficient time was allotted for the conference.	5.091		0.921
The conference format was very effective.	5.227		0.612
The objectives for this conference were clear.	5.318		0.646
The conference met its objectives.	5.409		0.590
The speakers and/or staff were helpful in action planning.	5.524		0.512
The action plan I developed will be useful.	5.296		0.564
The conference provided a needed forum to interact with other concerned individuals from across the country about issues surrounding the safe, legal implementation of I.D.E.A.	5.409		0.734
and,	Yes	No	blank
Were the presentations at a level that met your needs?	21	-	2

Open-ended Responses

Most Useful Aspects. The single most valued aspect of the conference was presentation of the status of the law and legal ramifications of the issues (8 references). Also frequently noted were parent advocate presentations sharing their experiences, views and concerns (5 references), the status and statistics regarding special needs students (4 references), and the provision of extensive handouts, articles, and other materials (4 references). The multidisciplinary expertise, clarification of policy development, and the opportunity to share in other states' experiences and models were also represented in open-ended comments (3 references for each of the preceding items). Two respondents each recognized as most valuable the presentation of political views, nursing issues and shared nursing experiences, lobbying techniques to use with legislators, and the in-depth treatment of delegation. Models and sources of funding and training issues (especially with non-licensed individuals) were also noted in singular comments.

Least Useful Aspects. The most frequent category of comments responding to identification of the least useful aspect of the conference were five comments protesting that there were no such aspects. However, some substantive criticisms were stated. These included three comments citing managed care and collaborative funding presentations, two respondents each who were least satisfied with presentations related to a) impacting policy, b) issues in child care, c) ethnic/cultural competence, and d) the luncheon presentations. Finally, one comment each noted dissatisfaction with medication study data, changes in education, absence of attention to home care, parents with more involved kids who are trying to utilize the system, and examples of what has happened in other states.

Presentation Levels. All of the respondents felt that the level of presentations met their needs. Nine respondents chose to elaborate their opinions. Of these comments, seven were complimentary, citing the value of the interdisciplinary approach, or noting the timeliness, professionalism, conscientiousness and thoroughness of the presentations and practicality of tangible issues and anecdotes. Of the two remaining comments, one recognized the limiting effects of conference time constraints, while the other noted that nursing issues were not in the area of the respondent's concern.

Future Conferences. While three respondents noted that no changes should be made, the most frequent suggestion (made by six respondents) was to provide more time for the exchange of ideas between participants (i.e., breakout groups). Four suggestions were made to lengthen the conference while shortening the length of the conference day, or provide more breaks to relieve its intensity and allow participants to take advantage of Colorado. Singularly cited suggestions included adding more educators, more case examples of policy implications, more strategies and models in use in other states, and adding a demographer to the group of presenters.

Other Comments. In response the request for other comments or suggestions about the conference, nine participants wrote expressions of satisfaction or thanked the conference organizers. Additional suggestions included shifting the timing of the action plan to the morning, establishing "job-alike network opportunities," and providing more opportunity to share existing policies and procedures. Finally, there were two complaints about the physical facilities of the hotel.

Section Summary

The ratings and comments provided to the Overall Conference Evaluation reveal that the majority of respondents were highly satisfied with the Policy and Practice Conference content, format, and outcomes. Rated statements received mean scores that were highly positive. Frequently cited "most valued aspects" included the report of the status of the law and legal ramifications, parental sharing, the status of children with special needs, and the handouts, articles, and other materials provided in conference notebooks. The most common suggestion was to create more opportunities for breakout groups and sharing of information and solutions among participants.

Participant Action Plans

Twelve participants submitted personal Action Plans, including two who submitted a joint plan. The typical Action Plan identified one to two problem areas (usually related), one or more related goals, and multiple strategies. For purposes of this report the elements of the plans have been broadly categorized to indicate the range of issues and strategies noted. (The Summary of Participant Action Plans presents the verbatim details of each proposal. Review of the Table is suggested to comprehend individual approaches to state problems.)

Problem Areas

The problem areas addressed in Action plans fell into six broad categories. These were advocacy on behalf of the children with special health care needs and their families, absent or inconsistent state policies for meeting special health care needs in schools, absent or inadequate supervision of health related services in child care, failure to provide health related services in schools, personnel preparation issues and interdisciplinary role ambiguity in delivery of services.

Advocacy. Four respondents identified problems related to the support of children with special health care needs and their families. The areas included lack of information about challenges and support for families in rural areas that might impact upon the attitudes and behaviors of preservice early childhood teachers; the need to create supportive linkages among families; the disabling impact of requiring that families not exceed minimal levels of resources to qualify for Medicaid and SSI; absence of awareness of the complexity of issues in serving children with special health care needs in the public school setting in a geographically diverse county system.

Service Shortfalls. Inability to deliver school health services owing to shortages of qualified, trained, and supervised personnel or owing to very poor nurse:student ratios were problem areas cited by three participants.

Policy. Two participants identified the absence of statewide policies (and related issues of risk management and liability) or conflict of policy with practice acts in meeting the special health care needs of students with disabilities.

Supervision of health related services. The absence or inadequacy of health services and poor standards for administration of medication in child care were identified by two respondents.

Personnel preparation. The need to design adequate and appropriate training of individuals responsible for implementing statewide policies and procedures regarding special health care needs was raised by one participant.

Role clarification. Ambiguity in the limits and purposes of interventions by various professionals in meeting the needs of children in Head Start was seen by one respondent as impeding smooth service delivery.

Goals

Five goal areas emerged in participant action plans; increasing availability of nursing resources, impacting statewide policy creation/revision and implementation of change, training those providing invasive health care procedures, impacting the approach to service delivery, and communication/information dissemination.

Increased nursing resources. Three participants noted increasing the numbers of or availability of nurses in school and child care settings as a goal in their plans.

Policy change and implementation. Two respondents expected to impact policy creation or revision on the state or county level to address children's special health care needs in school settings. Issues included addressing delegation, provisions for identifying, training, monitoring, supervising delegatees, and evaluation methods.

Training. Awareness and resources for ensuring a supply of properly trained individuals available to implement policies for provision of special health care services in schools and child care settings statewide were goals areas described in three plans.

Service delivery. Concerns with increasing the family-centeredness of the service delivery system, the cohesiveness of multidisciplinary teams, the effectiveness of family linkages with support networks, and the terms of eligibility for SSI were all cited once as focal goals.

Improved communication. Support for inclusion of children with need for invasive health care procedures was addressed in two plans. One of these centered on helping preservice teachers understand and perform their role as advocates for children and families. The other sought better communication (between Department of Education, State Health Office, Health Care Providers, Parents) to identify problems and design solutions.

Action Plan Strategies

The strategies identified to address the targeted goal areas fell in five groups: task force/coalition building, research, education, information dissemination, and lobbying.

Task force/coalition building. Strategies to build professional, administrator, parent, and/or advocate coalitions or task forces were cited 12 times in the plans. Tactics ranged from specific task-oriented state level task forces convened to design and enact statewide policy to multi-agency work groups intended to impact a single issue such as medication administration. Efforts aimed at coalition building were expected to: cross multiple disciplines, decrease fear of serving children who require invasive procedures, build interdisciplinary trust, establish common goals and supportive networks, enlist local community, parents, medical community support for the role of school nurses, streamline the process for service delivery, and assist family resource acquisition.

Researching issues and solutions. Eleven information gathering efforts were specified. Examples of strategies include: structured needs assessments, information gathering on the status NPAs and delegation and actual practice related to issues, seeking out other states' models and solutions, analyzing best practices cost/benefit ratios of providing adequate school health services, and evaluating the success of planned strategies.

Educating. Eight educational initiatives appeared as tactics. They included plans that ranged from college level curriculum development and delivery (of BSN units or seminars on the health issues of children with special needs) and training programs for paraprofessionals.

Disseminating. Sharing or reporting information on the conference issues with colleagues, administrators appeared as a strategy in six plans.

Lobbying. Six strategies that may be categorized as lobbying, either among legislators, professional organizations or state agencies were specified in the plans. In addition a seventh plan noted efforts to campaign within the participant's agency to draw attention to the importance of involvement of the school nurse in health planning.

Timeframe

Participants who submitted action plans cited timeframes for meaningful progress ranging from 3 days to mobilize first stages of a plan to more than 24 months to achieve the specified goals. The median estimated timeframe for meaningful progress was in the 4-6 month range.

Section Summary

The completeness of individual plans varied markedly as a function of both differential levels of sophistication with planning documents and level of immersion in the issues of the conference, as indicated in the discrepancies in detail and comprehension of differences between problem areas, goals and strategies. Nonetheless, the planning process may help participants focus their concerns and identify resources to impact problem areas. Overall review of the plans reveals that the most prevalent concerns related to: child/family advocacy; policy; service, training, and supervision inadequacies in meeting special health care in schools and child care; and, interdisciplinary role ambiguity in delivery of services. Targeted goal areas included nursing resources, policy creation/revision and implementation, training, approaches to service delivery, and communication, which were to be achieved through task force/coalition building, research, education, dissemination, and lobbying. Typically, meaningful progress of the plans was expected to occur in four to six months.

Objectives Assessment and Recommendations

The evaluation plan for the Conference on Developing Policy and Practice focused on four evaluation objectives:

1. Determination of the effectiveness of efforts to attract a miltistate, interdisciplinary audience.

2. Determination of effectiveness in raising awareness of issues pertaining to inclusion and invasive procedures and raising confidence in ability to impact inclusion.

3. Determination of the quality of the conference overall and of its constituent elements.

4. Determination of effectiveness in focusing participants' concerns regarding safe and legal implementation of IDEA related to invasive procedures for children with special health care needs.

Objective 1

A description of conference participants was compiled using the Participant Information Sheet and registration information to assess the effectiveness of efforts to attract an interdisciplinary audience. The results revealed reasonable success in attracting geographic diversity for the second conference since 19 states and the District of Columbia were represented (by registrants and speakers), bringing the cumulative total for the first two conferences to 27 states. Demographically, the respondents were more homogeneous (all white and predominantly female). Almost all were educated the baccalaureate level or higher (nearly half held masters' degrees). Furthermore, while positions in education and administration were represented, nearly two thirds held positions in nursing. Thus, the final conference may yet improve diversity in terms of ethnicity, gender, and profession/occupation. Most registrants had learned of the conference through the brochure or word-of-mouth.

Recommendations

1. Efforts to contact the remaining unrepresented states should be intensified.
2. Since physician and educator participation was low, dissemination of the *Proceedings* from these conferences should be targeted to these professions.
3. Use of electronic media and forums reaching diverse professions should be strengthened for dissemination of conference announcements.

Objective 2

Pre- and Post-Conference Self Assessments of awareness of conference issues and confidence in abilities to impact IDEA in participants' home states, as well as identification of major obstacles and progress or strategies in place to facilitate inclusion address Objective 2. Virtually all of the post conference awareness ratings were significantly increased over pre-conference levels. Confidence in abilities to contribute to safe, legal implementation of IDEA in the home state also rose significantly by the post-conference assessment. Open-ended responses revealed that the perceived obstacles to safe, legal implementation of IDEA were funding, inadequate staffing of school nurses, lack of awareness, knowledge and experience with standards and procedures, and existing statutes. At the post-conference assessment, 14 of 16 comments affirmed that the conference had heightened awareness of obstacles. Existing resources to support implementation included sophisticated state level plans or collaboration, supportive laws in place, expertise of individuals in key positions, and isolated inclusive programs already in place. In the post- assessment, the majority of respondents reported increased awareness of state assets but felt responsible to pursue more specific information.

Thus, pre-post comparisons revealed significant increases in awareness of the conference issues, as well as gains in confidence in ability to contribute to implementation of IDEA in the home states. The results of the Self-Assessments indicate significant success in achieving the major conference objective of raising awareness of the issues and strategies.

Recommendations

Recommendations emerging from analysis of the Self Assessments are as follows:

1. Despite a significant increase in participant awareness of the funding implications of implementation of IDEA relative to invasive procedures, its ranking as the lowest rated awareness item (at both the pre-and post- ratings) and frequent citation of funding as a major obstacle to implementation identifies funding as an issue meriting more attention in the final conference.
2. Participants' comments identifying the need for more information, especially regarding resources (technical and funding), safety and liability issues, and the specific health needs of the children re-affirm the importance of dissemination

of the conference proceedings and of publication of the conference issues in outlets that reach multiple disciplines.

Objective 3

Participants' perceptions of the quality of the conference (of its component elements and of the overall experience) were evaluated using the Session Rating Form and Overall Conference Evaluation. All presentations received positive ratings, with preferences indicated for sessions describing the current status of the law, the outlook for federal funding and national policy, and the experiences of specific children and their parents. Presentations of strategies, resources, and models fell in the middle ground, while video presentations and those addressing the status of child care and national education initiatives were less well received, although still positively rated.

The results of the overall Conference Evaluation also revealed that the majority of respondents were well satisfied with the Policy and Practice Conference content, format, and outcomes as indicated in favorable ratings and comments. No recommendations emerged from the rated statements, mean ratings of which were highly positive. Clearly, the most persistent request affecting the format of the final conference is the provision of more opportunities for participant interaction in the form of breakout groups and opportunities to share information and solutions.

Recommendations

Based on the data summarized above, the following recommendations are offered:

1. Utilize small group interactions to increase exchange between participants and networking opportunities, as well as to relieve the intensity of the program.
2. Offer more models and strategies in place in other states.

In addition, the following recommendation, while based on a single comment, may also merit attention:

3. Strengthen educator input in the program.

Objective 4

As indicated in Action Plans, several participants had focused their concerns regarding safe and legal implementation of IDEA related to invasive procedures for children with special health care needs by the close of the conference. The low percentage of completed plans (40% of all registrants, 52% of those who completed evaluation packets) was disappointing. A contributory factor may be the timing of the action planning as the last session of the conference. Some participants were simply exhausted by the intense schedule and others had to leave for airline flights. However, Action Plans appeared to help participants define their concerns regarding safe and legal implementation of IDEA related to invasive procedures for children with special health care needs by identifying problem areas participants' expected to influence, their goals, and the strategies they expected to apply to achieve the goals. The problem areas were child/family advocacy, policy, service, training, and supervision inadequacies in meeting special health care in schools and child care, and interdisciplinary role ambiguity in delivery of services. The cited goal areas included nursing resources, policy creation/revision and implementation, training, approaches to service delivery, and communication, which were to be impacted through task force/coalition building, research, education, dissemination, and lobbying.

Recommendations. Action Plans submitted by the 1995 conference participants suggest the following modifications for the third conference:

1. More models of successful or in-progress programs should be presented;
2. Parent involvement in presentations should be increased;
3. More detailed information on successful strategies of change agents should be emphasized; and,
4. The roles of various professions in collaborating on these issues should be more thoroughly explored in the final conference.

Summary

The Conference on Developing Policy and Practice, held June 16 - 17, 1995, in Denver, Colorado, addressed the IDEA as it relates to invasive procedures required by some young children with special health care needs. A comprehensive objectives-driven evaluation assessed conference effectiveness in reaching a diverse national audience, increasing awareness of focal issues associated with invasive procedures in the safe and legal implementation of IDEA, delivering high quality content that satisfied participants, and assisting participants in focusing their personal agendas for impacting safe and legal implementation of IDEA related to invasive procedures.

Utilizing five instruments designed or adapted to address these objectives, the evaluation results indicated that:

1. The conference was reasonably successful in reaching a geographically diverse audience. But less successful in attracting demographic and professional diversity. The final conference may increase both the geographic and professional representation of attendees by improving announcement dissemination strategies and strengthening content to appeal to other professions and parents of children with special health care

needs. Efforts to disseminate the *Proceedings* should include underrepresented (in conference attendance) professions, especially medicine.

2. The conference was very successful in increasing awareness of focal issues. Knowledge of financial implications of implementation of IDEA related to invasive procedures, while significantly increased, merits more extensive coverage.

3. Presentations were favorably rated and participants were very satisfied with the conference as a whole. Opportunities for information sharing among participants should be increased. Broader geographic and professional representation among speakers is desirable.

4. A follow-up evaluation should be conducted to determine whether participants utilized the Action Plans or other conference components to personally impact safe and legal implementation of IDEA related to invasive procedures in their home settings. In addition, more information on model programs, parental involvement, strategies of change agents, and professional role articulation are desirable for the last conference.

Implementation of the evaluation plan for the Policy and Project Conference provided objective data in support of the conclusion that the conference substantially met three of its four objectives, and demonstrated reasonable success in meeting a fourth (attraction of a diverse national audience). Finally, the feedback from participants was useful in deriving a set of recommendations for the improvement of future conferences in this series.

Appendices

Appendix A

Participant Information Sheet

POLICY AND PRACTICE - JUNE, 1995
PARTICIPANT INFORMATION SHEET

Note: Items 1 - 4 requested identification of the respondent (i.e., name, specific position title, work address and telephone number) and will not be reported here. Listed below in bold type are the comments, frequencies, and percentages they represent of the responses provided by the 23 conference participants who completed the Participant Information Sheet.

Totals may exceed 23 respondents or 100% for items 5,6, and 9 since respondents often endorsed more than one alternative in these items.

5. Please indicate your current position with a check mark.

N	(%)	
1	(4)	early childhood educator
-	-	early childhood special educator
2	(9)	other educator (please specify): ***University School of Nursing*** ***Paraprofessional***
2	(9)	social worker
-	-	child care provider
15	(65)	nurse (please specify): ***Pediatric*** ***PNP Student*** ***PNP Nurse Educator*** ***School Nurse(4)*** ***Special Ed School Nurse*** ***Clinical Coordinator for Div. for Children with Special Health Care needs(DPH)*** ***State Nursing Consultant*** ***School Nurse Consultant*** ***RN in Early Childhood Program*** ***Neurology and Rehabilitation, RN MSN*** ***Part H Service Coordinator***
1	(4)	health department staff
-	-	medical foster parent coordinator
-	-	child care director
-	-	developmental disabilities/special education coordinator
1	(4)	psychologist
1	(4)	speech therapist/specialist
-	-	physical therapist
-	-	occupational therapist
2	(9)	parent
-	-	physician
-	-	staff development/training/inservice coordinator
2	(9)	administrator

		State Department of Education, Special Education
		State Health Office, Director of Comprehensive School Health Services
3	(13)	other
		University professor in Special Education and psychology
		Health Care Policy Staff member - state level
		Support person for EC Special Educators

6. Please indicate the highest level of academic work completed: (Check one.)

N	(%)	
-	-	No earned diploma
-	-	GED
-	-	High school diploma
1	(4)	Some college but no degree
2	(9)	Associate degree/community college degree
-	-	LPN
6	(26)	RN
4	(17)	Bachelor's degree in:
		Nursing & Education
		Nursing(2)
11	(48)	Master's degree in:
		Special Education
		Nursing(2)
		Advanced Nursing Science
		Nursing care of Children and infants
		Maternal child health nursing
		Nursing and political science
		Speech-Language Pathology
		Education
		Education plus school psychology
		Health Education
		Science
		Social work
1	(4)	PhD in:
		Nursing
2	(9)	EdD
-	-	MD
-	-	Law Degree
-	-	Other

7. Ethnicity: (Check one.)

N	(%)	
-	-	American Indian/Alaskan Native
-	-	Asian/Pacific Islander
-	-	Black/African American
23	(100)	Caucasian/White
-	-	Hispanic/White
-	-	Other

8. Gender: (Check one.)

N	(%)	
22	(96)	Female
1	(4)	Male

9. So that we may most effectively reach concerned parties, please indicate how you learned of this conference (check one):

N	(%)	
12	(52)	Brochure mailing
-	-	Electronic mail/Internet
2	(9)	Recommended or sent by a participant in 1994 conference
6	(26)	Word-of-mouth
5	(22)	Other (please specify):

Saw report from the first conference and made an inquiry
Brochure from Kentucky Department of Education
UAP newsletter from JFK at UCHSC
Clinical coordinator at VNS
State Part H Coordinator

Appendix B

Pre- and Post-Conference Self-Assessments

PRE- and POST-CONFERENCE SELF-ASSESSMENTS
June, 1995

Listed below in bold type beneath each question is a summary of the responses provided by the 23 (of 30) conference attendees (76%) who returned evaluation packets. Pre-conference descriptive statistics are based upon 23 respondents. Since Respondent #09 did not complete Post-conference assessment, the sample size for Post conference descriptive statistics and for the pre-post comparison are based on 22 respondents. Pre- and post conference self-assessments of awareness and confidence are labelled in capitals, presenting the frequency (freq.) of response in each category, the percentage of respondents (%) selecting each alternative, the mean score for the item (M), the standard deviation (SD) and the number of respondents who left the item unanswered (missing). Paired *t*-test results are also reported for each item showing significance of differences in the pre and post conference assessments. The mean difference (Diff), standard deviation (SD), test statistics (*t*), degrees of freedom (*df*), and probability level (*p*) are listed. All tests were two-tailed.

Pre- and post-conference open-ended comments to items 13 and 14 are provided verbatim.

Please rate your level of awareness of each of the issues listed below, using the following six point scale:

1 completely unaware	3 slightly unaware	5 somewhat aware
2 somewhat unaware	4 slightly aware	6 completely aware

1. My state's legislation impacting the care of children with disabilities with special health care needs.

		unaware			aware		
		1	2	3	4	5	6
PRE Mean = 4.522 SD = 1.344	**freq**	**1**	**1**	**3**	**3**	**10**	**5**
N=23	**%**	**4**	**4**	**13**	**13**	**43**	**22**
POST Mean = 5.024 SD = 0.901	**freq**	**-**	**-**	**2**	**2**	**11**	**6**
N = 21	**%**	**-**	**-**	**10**	**10**	**52**	**28**

PRE-POST Comparison

Diff = 0.452 SD of diff = 1.117 *t* =1.856 *df* = 20 *p* < .078

2. The status of delegation of nursing tasks in my state.

		1	2	3	4	5	6
PRE Mean = 4.522 SD = 1.675	**freq**	**2**	**2**	**2**	**1**	**8**	**8**
N= 23	**%**	**8**	**9**	**9**	**4**	**35**	**35**
POST Mean = 5.381 SD = 0.794	**freq**	**-**	**-**	**-**	**3**	**7**	**11**
N = 21	**%**	**-**	**-**	**-**	**14**	**33**	**52**

PRE-POST Comparison

Diff = 0.714 SD of diff = 1.146 *t* = 2.855 *df* = 20 *p* < .010

3. Needed amendments to my state's Nurse Practice Act for safe, legal implementation of I.D.E.A.

			1	2	3	4	5	6
PRE	**Mean = 3.565 SD = 1.727**	**freq**	**4**	**4**	**1**	**6**	**5**	**3**
	N= 23	**%**	**17**	**17**	**4**	**26**	**22**	**13**
POST	**Mean = 5.238 SD = 0.625**	**freq**	-	-	-	**2**	**12**	**7**
	N = 21	**%**	-	-	-	**10**	**57**	**33**

PRE-POST Comparison

Diff = 1.476 SD of diff = 1.504 *t* = 4.498 *df* = 20 *p* < .000

4. Resources available to assist implementation of I.D.E.A. in my state.

			1	2	3	4	5	6
PRE	**Mean = 3.826 SD = 1.749**	**freq**	**3**	**3**	**4**	**3**	**5**	**5**
	N= 23	**%**	**13**	**13**	**17**	**13**	**22**	**22**
POST	**Mean = 4.952 SD = 1.024**	**freq**	-	**1**	-	**5**	**8**	**7**
	N = 21	**%**	-	**5**	-	**24**	**38**	**33**

PRE-POST Comparison

Diff = 1.286 SD of diff = 1.271 *t* = 4.637 *df* = 20 *p* < .000

5. Measures needed for pre- and in-service preparation for safe, legal implementation of I.D.E.A. in my state.

			1	2	3	4	5	6
PRE	**Mean = 3.870 SD = 1.576**	**freq**	**3**	**2**	**2**	**7**	**6**	**3**
	N= 23	**%**	**13**	**9**	**9**	**30**	**26**	**13**
POST	**Mean = 5.048 SD = 1.024**	**freq**	-	**1**	-	**4**	**8**	**8**
	N = 21	**%**	-	**5**	-	**19**	**38**	**38**

PRE-POST Comparison

Diff = 1.333 SD of diff = 1.278 *t* = 4.781 *df* = 20 *p* < .000

6. Resources available to assist pre- and in-service training regarding medically invasive procedures.

			1	2	3	4	5	6
PRE	**Mean = 3.609 SD = 1.803**	**freq**	**4**	**3**	**4**	**4**	**3**	**5**
	N= 23	**%**	**17**	**13**	**17**	**17**	**13**	**22**
POST	**Mean = 5.048 SD = 1.024**	**freq**	-	**1**	-	**4**	**8**	**8**
	N = 21	**%**	-	**5**	-	**19**	**38**	**38**

PRE-POST Comparison

Diff = 1.333 SD of diff = 1.390 *t* = 4.394 *df* = 20 *p* < .000

7. Funding implications of safe, legal implementation of IDEA in my state.

		1	2	3	4	5	6
PRE **Mean = 3.174** **SD = 1.337**	**freq**	**3**	**4**	**7**	**4**	**5**	**-**
N= 23	**%**	**13**	**17**	**30**	**17**	**22**	**-**
POST **Mean = 4.762** **SD = 1.136**	**freq**	**1**	**-**	**1**	**3**	**12**	**4**
N = 21	**%**	**5**	**-**	**5**	**14**	**57**	**19**

PRE-POST Comparison

Diff = 1.429 SD of diff = 1.165 t = 5.620 df = 20 p < .000

8. Agency liability issues relating to safe, legal implementation of IDEA.

		1	2	3	4	5	6
PRE **Mean = 3.409** **SD = 1.403**	**freq**	**3**	**3**	**4**	**6**	**6**	**-**
N = 22	**%**	**13**	**13**	**17**	**26**	**26**	**-**
POST **Mean = 5.190** **SD = 0.981**	**freq**	**-**	**1**	**-**	**2**	**9**	**9**
N = 21	**%**	**-**	**5**	**-**	**10**	**43**	**43**

PRE-POST Comparison

Diff = 1.714 SD of diff = 1.146 t = 6.852 df = 20 p < .000

9. Individual liability issues relating to safe, legal implementation of IDEA.

		1	2	3	4	5	6
PRE **Mean = 3.727** **SD = 1.316**	**freq**	**1**	**4**	**3**	**7**	**6**	**1**
N = 22	**%**	**4**	**17**	**13**	**30**	**26**	**4**
POST **Mean = 5.095** **SD = 1.044**	**freq**	**-**	**1**	**-**	**4**	**7**	**9**
N = 21	**%**	**-**	**4**	**-**	**18**	**32**	**41**

PRE-POST Comparison

Diff = 1.333 SD of diff = 1.065 t = 5.739 df = 20 p < .000

10. Actions that can promote systems change to achieve safe and legal implementation of I.D.E.A. in my state.

		1	2	3	4	5	6
PRE **Mean = 3.364** **SD = 1.293**	**freq**	**2**	**4**	**5**	**6**	**5**	**-**
N = 22	**%**	**9**	**17**	**22**	**26**	**22**	**-**
POST **Mean = 5.000** **SD = 0.949**	**freq**	**-**	**-**	**1**	**6**	**6**	**8**
N = 21	**%**	**-**	**-**	**5**	**28**	**28**	**38**

PRE-POST Comparison

Diff = 1.619 SD of diff = 1.359 t = 5.458 df = 20 p < .000

11. Actions that can influence policy to achieve safe and legal implementation of I.D.E.A. in my state.

			1	2	3	4	5	6
PRE	**Mean = 3.341 SD = 1.148**	**freq**	1	5	5	8	3	-
	N = 22	**%**	4	22	22	34	13	-
POST	**Mean = 4.905 SD = 0.831**	**freq**	-	-	1	5	10	5
	N = 21	**%**	-	-	5	24	48	24

PRE-POST Comparison

Diff = 1.548 SD of diff = 1.182 t = 5.999 df = 20 p < .000

12. The complexity and nature of problems confronted by parents of children with special health care needs.

			1	2	3	4	5	6
PRE	**Mean = 5.348 SD = 0.573**	**freq**	-	-	-	1	13	9
	N = 23	**%**	-	-	-	4	56	39
POST	**Mean = 5.381 SD = 0.740**	**freq**	-	-	1	-	10	10
	N = 21	**%**	-	-	5	-	48	48

PRE-POST Comparison

Diff = 0.048 SD of diff = 0.805 t = 0.271 df = 20 p < .789

13. The importance of cultural competence in service delivery to children with special health care needs and their families.

			1	2	3	4	5	6
PRE	**Mean = 4.761 SD = 0.903**	**freq**	-	-	3	4	12	4
	N = 23	**%**	-	-	13	17	52	17
POST	**Mean = 5.429 SD = 0.811**	**freq**	-	-	1	1	7	12
	N = 21	**%**	-	-	5	5	30	57

PRE-POST Comparison

Diff = 0.738 SD of diff = 1.221 t = 2.771 df = 20 p < .012

Using the scale below, please rate again your confidence in your ability to effect item 14:

1 completely unsure	3 slightly unsure	5 somewhat confident
2 somewhat unsure	4 slightly confident	6 completely confident

unsure **confident**

14. Contribute to safe, legal implementation of IDEA in my state.

			1	2	3	4	5	6
PRE	**Mean = 3.810 SD = 1.401**	**freq**	1	4	2	7	5	2
	N = 21	**%**	4	17	9	30	22	9
POST	**Mean = 4.750 SD = 0.786**	**freq**	-	-	-	9	7	4
	N = 20	**%**	-	-	-	45	35	20

PRE-POST Comparison

Diff = 0.842 SD of diff = 1.463 t = 2.509 df = 18 p < .022

15.pre What are the major obstacles to safe, legal implementation of IDEA in your state?
post Has participation in the conference helped you identify obstacle(s)...

PRE

01 The language of our Nurse Practitioner statute, which does limit to some extent the delegation of tasks to non-licensed individuals.
02 1) Staffing of nurses; 2) Money
03 Staffing of nurses; Money Appropriated
05 Regarding nursing - I'm not sure. I do know we do not have adequate numbers of school nurses in Hawaii.
06 blank
07 1) Lack of nursing supervision for large number of students served.
2) Funding sources
3) Safety
4) Multiple sites with children who are medically fragile due to inclusion efforts.
08 Funding
09 It seems inclusion is being treated much as the ostrich reacts to fear. Finding also seems to be an issue.
10 Money and need for more school nurses - reduced student/nurse ratio.
12 Legislative funding issues.
14 Funding, knowledge, and experience, but, they are working hard to overcome these obstacles.
15 I am not that aware of the obstacles.
16 Lack of knowledge of standards and procedures.
17 Funding issues, personnel, lack of awareness, poor community involvement at the secondary level in our school district. (education 6-12)
19 Don't know
20 Been focused in studies for three years - not aware - Imagine awareness, money, laws.
21 I'm not sure. Maybe lack of staff and money.
22 Cooperation of Department of Education to look at importance of health services to this population.
23 Availability of services

POST

01 Yes - our state statutes defining professional practice.
02 Yes - finances/funding
03 Yes - finances/funding
05 I'm not sure - I need to investigate when I return home.
07 Yes 1)delegation issue; 2)medication policies; 3)government involvement; 4)networking with resource people in other states
08 yes
10 Yes - safety on delegation issues
11 Yes - I would like to see the nurse:pupil ratio mandated and feel I know how it could be funded through Medicaid and private insurance; and now know better how to implement it.

12 Yes - The "reality": of current status for school nurses and pitfalls re: delegatory clause.
16 see next question
18 Yes- begin to ask questions of how this is implemented in my children's school district.
19 Yes
20 Yes - i need to find out what is happening in my state.
21 Yes - funding/educating administrators etc. re: safe delegation
22 Yes - Presentation by Board of Nursing and Lawyers.
23 Yes

16. What resources/strategies are already in place in your state for safe, legal implementation of IDEA? (If "yes", please note them.)
post Has participation in the conference helped you identify resources/strategies...

PRE

01 Interagency partnership among the Departments of Education, Health, and Human Services to bring down barriers to service delivery to families and to "pool" resource 0 human, material and financial - to that end.
02 Council of School Nurses; Basic and Specialized Health Care Procedure Manual
03 Council of School Nurses - Basic and Specialized Health Care Policy and Procedure Manual
05 I think these questions (5-11) reflect more a nursing perspective - my knowledge base is very limited in that area.
07 State School Nurse consultant - Exceptional knowledge of IDEA by Special Ed. Administrator in the district
09 Some individual school districts are attempting to implement IDEA.
10 1) MASSTART - MASS technology Assistance Resource Team (DPS)
2) Children's Hospital Medical Center Project School Care and their school nurse training program presently being replicated in Pediatric Tertiary Care facilities throughout Massachusetts.
14 Full inclusion with most children. Services are provided for them.
15 I am not sure
16 Not sure.
17 Delegation clause is in place re Nurse Practice Act, RNs may delegate to nonlicensed personnel. Distribution of licensed personnel available in nearly every county, High levels of expertise in our health department and ESUs. Strong administrative support in the student services department in our district.
19 Don't know
20 Will have to look around to see.
21 Part H resources; others, I'm not sure.
22 Have state plan and State Strategic Plan - Health Component weak.

POST

05 See above - but this conference has definitely raised my awareness level of the need for better collaboration between special educators and school health providers.

07 Will still need to inquire about specifics in the State of Wisconsin and will do through school nurses of Wisconsin organizations.

08 No

11 Yes, legal strategies

16 I haven't had a chance to read all the material and absorb all the of the information. Probably after reading all of the helpful information, I might feel more knowledgeable.

18 Yes

19 Yes

20 Yes- But I need to know where to plug into what's happening.

21 I'm not sure I can answer this.

22 Yes - need to work harder with FL Board of Nursing and local universities.

23 Yes

Appendix C

Overall Conference Evaluation

POLICY AND PRACTICE - June 16-17, 1995
OVERALL CONFERENCE EVALUATION

Listed below in bold type beneath each question is a statistical summary of the responses provided by 22 of 23 participants who returned evaluation packets (one respondent, #9, did not complete the Overall Conference Assessment). For each rated statement the frequency (freq.) of response in each category, the percentage of respondents (%) selecting each alternative, the mean score for the item (M), the standard deviation (SD), and the number of respondents who left the item unanswered (missing) is presented.

Instructions: *Considering the conference as a whole, please circle the number that best expresses your opinion about the following statements using the six-point scale below:*

1 = strongly disagree	3 = slightly disagree	5 = moderately agree
2 = moderately disagree	4 = slightly agree	6 = strongly agree

1. The overall quality of the speakers was excellent.
M = 5.527 SD = 0.456

	disagree				agree	
	1	2	3	4	5	6
freq	**-**	**-**	**-**	**-**	**6**	**16**
%	**-**	**-**	**-**	**-**	**27**	**73**

2. The educational value of the conference was excellent.
M = 5.591 SD = 0.503

	1	2	3	4	5	6
freq	**-**	**-**	**-**	**-**	**9**	**13**
%	**-**	**-**	**-**	**-**	**41**	**59**

3. Sufficient time was allotted for the conference.
M = 5.091 SD = 0.921

	1	2	3	4	5	6
freq	**-**	**-**	**2**	**2**	**10**	**8**
%	**-**	**-**	**9**	**9**	**45**	**36**

4. The conference format was very effective.
M = 5.227 SD = 0.612

	1	2	3	4	5	6
freq	**-**	**-**	**-**	**2**	**13**	**7**
%	**-**	**-**	**-**	**9**	**59**	**32**

5. The objectives for this conference were clear.
M = 5.318 SD = 0.646

	1	2	3	4	5	6
freq	**-**	**-**	**-**	**2**	**11**	**9**
%	**-**	**-**	**-**	**9**	**50**	**41**

6. The conference met its objectives.
M = 5.409 SD = 0.590

	1	2	3	4	5	6
freq	**-**	**-**	**-**	**1**	**11**	**10**
%	**-**	**-**	**-**	**4**	**50**	**45**

7. The speakers and/or staff were helpful in action planning.

		disagree				agree	
		1	2	3	4	5	6
M = 5.524 SD = 0.512	freq	-	-	-	-	10	11
Missing = 1 (4%)	%	-	-	-	-	48	52

8. The action plan I developed will be useful.

		1	2	3	4	5	6
M = 5.296 SD = 0.564	freq	-	-	-	1	12	6
Missing = 3 (14%)	%	-	-	-	5	60	30

9. The conference provided a needed forum to interact with other concerned individuals from across the country about issues surrounding the safe, legal implementation of I.D.E.A.

		1	2	3	4	5	6
M = 5.409 SD = 0.734	freq	-	-	-	3	7	12
	%	-	-	-	14	32	54

10. Which aspects of the conference did you find most useful?

Respondent #:

01 **The information provided regarding the parameters of licensure acts (nurse practice, medical practice, pharmacist) and their impact on policy development for risk management and liability in schools. Training issues, especially with non-licensed individuals.**

02 **The sharing of information from a variety of states. Legal issues addressed.**

03 **Parent advocates sharing experience. Nurses from other states sharing experiences. Legal aspects.**

05 **I especially like having the notebook with all materials included. I also liked the mix of disciplines - law, education, etc.**

06 **Parent views and concerns**

07 **Nursing issues were very well presented.**

08 **Discussions about the laws and accountability.**

10 **Legal issues of delegation., Political views.**

11 **B. Rosenberg; T. Johnson; L. Siderius (Establishing policy); P. Schroeder (Luncheon Address)**

12 **Legal interpretations**

13 **Delegation in depth; Lobbying**

14 **Meeting the families, with their own situations and seeing how different things work, and seeing how Colorado does their program in their school districts, and also how other school districts run.**

16 **Applicability to my own concerns about student care.**

17 **Case review definitions, and delegation clause information, approach and techniques to use when contacting our legislators. The status and statistics regarding special needs students, procedures and task performance in Colorado schools gives me a basis for comparison. Written materials---Wow!**

Respondent #:

18 Parents' input, anecdotes clarifying policy. Handouts clarifying speakers intent, articles.
19 Variety of expertise
20 Broad information about special needs kids.
21 Models and sources of funding -- This is what I need to know more about. Also, survey results were interesting, Also delegation, child care.
22 Board of Nursing and Lawyer
23 Lots of variety. The handout - wonderful.

11. Which aspects of the conference did you find least useful?
Respondent #:

01 Although interesting, some of the least directly applicable information to my immediate situation were the studies on chid care services and the third-party payor presentation.
02 Managed Care & Collaborative funding.
03 Managed care presentations. Concern for children: Quality and Safety in Child Care
05 None
07 Study data and legal opinion of assistant to DA.
10 All of interest.
11 All useful
12 Luncheon presentation
14 n/a
15 The lunch presentations were difficult to follow. I preferred the opportunity to network with others.
16 There was non -- all was appropriate.
17 I desired more specifics about ethnic/cultural competence issues - perhaps in a different arena that deals with multiculturalism... I found the change in education presentation somewhat confusing.
18 My area is home care -- the effect of these policies on home care would have been more helpful. However, I understand this was not the focus of the conference.
19 Parents with more involved kids who are trying to utilize the system.
20 Examples of what has happened in other states - stories.
21 Impacting policy. This information was very repetitive for me.
22 Aspect of cultural diversity could be handled better.

12. Were the presentations at a level that met your needs?

	Yes	No	Blank
freq	**21**	**-**	**2**
%	**100**	**-**	

Please explain:
Respondent #:

01 For the most part, the discussion of salient issues was extremely beneficial -- both formally and informally.
Respondent #:

05 Articulate and professional - I liked the tone and the seriousness - people were conscientious and thorough.
07 Clear, timely - focus was clearly nursing-related and met my field of expertise.
08 Not being a nurse, much of the discussions were not in the areas of my concerns.
10 Varied professional backgrounds
17 Practical strategies and their application, tangible issues and anecdotes rather than ambiguous graphs and statistics, Dialogue always helps. Sometimes the time constraints cut things off. i know it is difficult to maintain a schedule.
20 I have been out of the circuit for three years., Gave me an introduction to what's going on.
21 Most were very clear and helpful in presentations.
23 Information was from so many points of view, it gave me a well-rounded view to lots of areas.

13. What changes would you suggest for conferences like this to be held in the future?

Respondent #:

01 Adding a day or 1/2 day for breakout sessions to address some areas in greater depth, e.g., legal aspects, training aspects, collaboration aspects, policy components.

02 Breakout sessions - concurrent sessions - for sharing of information.
03 Divide time rather than go all day. Possibly have am session, afternoon off, and evening session. To help prevent overload. Breakout sessions for sharing - ex., group according to positions, such as nurses, teachers, etc.
05 Include more educators!! Where were the JFK - Colo UAP people?? Not your fault they didn't come bit I was disappointed that educators weren't present - especially since we deal with these kids all day long - do you have an educator on your conference planning committee?
07 Three days - shorter conference length of day so out-of-state people could enjoy the sites of Colorado!
10 More time for sharing between states and disciplines
11 None- just great!
13 Please send brochures to all districts in CO and CO school nurses
14 n/a
15 I would allow more time for interaction between participants
16 Don't make lunch a "working lunch" - allow time for people to visit/share ideas, resources, etc.
17 More stretch time. Take care of housekeeping issues up front - bathroom locations, invite refreshment breaks as needed. I always felt I was interrupting something if I needed to get up. At least one social lunch - work, work, work! Ha!
18 The more case examples of policy implications, the better.
19 I was very good {as written by respondent, assume "It was very good" was intended message}

Respondent #:

21 Three days and more breaks for networking. Also, more presenters from other states, i.e., strategies, models in other states.

22 Add demographer to your list of presenters.

14. Other comments or suggestions

Respondent #:

01 It was most enjoyable and appeared well organized yet relaxed. I look forward to your third conference on this important issue.

05 Overall, I think the conference was excellent -- thank you!! Obviously a lot of hard work and thought went into the planning and implementation.

07 Thanks for a great time- The Wisconsin people.

10 Great experience - informative. Beautiful state!

11 I wished the lights above Ms. Schroeder had not been burned out (which is what the hotel's luncheon waitress informed me when I suggested she turn on the lights over Mr. Schroeder). Also, I would suggest to the hotel that they have specific rooms for people with pets, as there were fleas in my room. I didn't complain because the insecticide would have bothered me as much as the fleas. Ha Ha

13 Conference rooms were freezing

14 n/a

16 Thanks for being so well organized -- thanks for the great materials , handouts, etc. Thanks for the great support/ it was wonderful. I didn't get a brochure for this conference at my school district but heard about it from someone t another agency. Please invite me next year!

17 A wonderful wealth of information - almost overwhelming. Really warm, personable hosting staff. Denver should be proud! Thanks!

18 See 11.

19 No

20 You have a host of resources/experts on hand to respond to all our concerns.

21 Do action plan in am - not at very end - made Saturday a half day.

22 Need to establish more job-alike network opportunities -- more opportunity to share existing policies, procedures, etc.

23 I enjoyed the conference a lot - a lot if things (areas) stimulated my interest to learn more and become more involved.

Appendix D

Action Plan Summary Table

Participant Action Plans - 1995 Conference

Participant	Problem Area	Goal	Action Plan	Progress
01 AK Spec. Ed.	1) Lack of school district written policies and procedures to address risk management and liability issues pertaining to meeting the special health care needs of students with disabilities. 2) Adequate and appropriate training of individuals implementing such policies and procedures.	Arkansas recently legislated mandated that items 1) & 2) (to left) be addressed. By school year 1996-97, all districts shall have in place such policies and procedures, and shall have properly trained individuals available to implement them.	Task Force (representing education, medical fields, other health care professionals, advocates, legal experts, etc.) established to develop prototype policies/procedures and training modules for above goals. Task Force also to make recommendations to State Board of Education on rules and regs. regarding professional roles and responsibilities, training, facilities, and use of supportive personnel. First Task Force meeting is July 25, 1995. I am responsible for overseeing the work of the Task Force and meeting the mandates established by the legislature. An initial strategic plan is in place to guide work of Task Force. Revisions anticipated as work progresses. South Atlantic Regional Resource Center (SARRC) is assisting Arkansas with this undertaking. A collaborative partnership is in place among the health, human services and education departments to facilitate and enhance this initiative.	3-6 mos.
02 WV Schl Nurse	Nurse:Pupil ratio is inadequate. Presently law states 1 school nurse for every 1500 students, K-7. Nurses actually service students preschool-12.	To meet or exceed the nurse to pupil ration of 1 nurse to 1500 students K-12.	1) Continue annual needs assessment statewide. 2) Continue to lobby state legislators to achieve goal. 3) Share information of annual statewide needs assessment with county administrators, State Board of education members, legislative community. 4) Educate the local community, parents, medical community and other of the role and importance of school nurses. 5) Work with state school nurse organization for assistance and support. 6) Work through national school nurse organization for additional assistance and support.	?
03 WV Schl Nurse	shared plan with Participant 02 - see above		Have been working toward this for a long time.	?

04 KY Asst. Prof Education	Lack of information about challenges and support for families and young children in far west Kentucky and ways to make information impact the attitudes and behaviors of preservice early childhood teachers.	Help preservice teachers understand and perform their role as advocates for children and families.	1) Collect data. 2) Contact local and state agencies. 3) Develop curriculum. 4) Present to students. 5) Evaluate results.	blank
05 - 14	No action plans submitted			
15 CO Head Start Coord.	Clarification of the roles of different professionals involved in the multidisciplinary staffings of the special needs Head Start child. Collaboration of the participants within the boundaries of their roles for smooth delivery for children participating in the Head Start.	An organized family-centered approach to service delivery for children participating in the Head Start.	1) Obtain as much information about my own role as I am able through my employer, the state board and other resources available. 2) Share information I received here with other staff at my facility and work with management to affect changes with the other agencies involved with our students. 3) Formulate a plan for ongoing dialogue and collaboration wit the involved agencies and including recommendations of the Health Service Advisory Committee. 4) Set goals with the different agencies involved to streamline the process for service delivery.	3-6 mos.
16 NE RN Schl Nurse	The status of delegation of nursing tasks (special care procedures) in the state of Nebraska. Policy change at the district level statewide to ensure delegation as addressed in our Nurse Practice Act is being complied with in the delivery of services to children throughout the state's schools.	School district policy on job description addresses delegation, provisions for identifying, training, monitoring, supervising delegatees, means of evaluation etc., will be in place by the conclusion of the upcoming school year.	1) Obtain models/policies from districts with delegation addressed in their policy. 2) Share information through professional nursing organizations re: Nationwide Survey Results of Special Care Procedures being done in schools (Judith Igoe) Report, the delegation clause of our Nurse Practice Act, tasks to be delegated, not to be delegated, delegatees, etc. 3) Actively campaign for the assessment of special needs students on enrollment by the nurse. Our MDT rarely involves the nurse on initial interview. 4) Share reauthorization of IDEA information with nursing peers, professional colleagues, and all school staff/administrators to advocate for students with special needs. Encourage contact with legislators to reauthorize and reallocate funding. 5) Communicate with the University School of Nursing re: the status of delegation preparation education for currently enrolled students and delegation preparation training provision for area school nurses through their	6 mos.

			program or through Carol Iversen School Nurse Consultant, Lincoln, NE. 6) Obtain resource materials re: tasks, procedures, monitoring, supervising, training etc, if paraprofessional and delegation.	
17	No action plan submitted			
18 MO RN MSN CNS Ped.	Connecting patient/families to fitting, supportive other families	Patient/family will demonstrate/verbalize connection with support networks.	1) Research available supports 2) Contact UAP, Pediatricians, Program presenters, others involved with other patients/families. 3) Assist family to connect with resources by providing opportunities for them to interact with others. 4) Evaluate success of plan about three months with Family Z and Family M. 5) Revise plan to attain mutual goals with patient/family as needed.	4-6 mos.
19 CO MSW soc. wrker	In a large, geographically diverse county system, we would like to increase awareness of the complex issues involved for children with special health care needs in the public school setting.	Create a committed team ("multidisciplinary") that will provide resources to each other and to the JeffCo (*county abbreviation*) community to facilitate IDEA for special needs kids.	1) Identify/target individuals and groups. (School Board members, all educators, paraprofessionals, school health personnel, school administrators, families in both the public and private schools in our county, related agencies (e.g., advocacy groups, ARC, public health sector, local hospitals and health providers, Part H providers, legal advisors.) 2) Pull together people who show interest in this area to begin dialogue of an interdisciplinary task force. 3) identify common goals for the children in the area taking into consideration the various disciplines - reducing fears and gaining trust and working together on the common goal of networking expertise of all those interested parties.	24 mos. minimum
20 ND Asst. Prof. Nursing			1) Contact State Board of Nursing and discuss issue of delegation. What is happening? How is the issue of delegation affecting nurses and special care kids? 2) Check status of school nurse proposal in the state. 3) Discuss with Special Education Chair on campus a) what is happening in special education with special needs kids, b) How are kids needs met in school, c) Who gives meds, does complex treatments? 4) Discuss with Kath. Gustafsen, Special Education Division to see what is happening to on issues in ND from state level.	

			5) Consider seminar on "special needs kids" with health care issues for BSN students. 5) Consider "special needs" as a unit in curriculum to teach BSN students.	
21	No action plan submitted			
22 FL Dir. Comprens. Schl Health Svc.	Lack of school health services delivered by qualified, trained, supervised personnel for ESE students (really for all students)	Better communication between Department of Education, State Health Office, Health Care Providers, Parents to identify problems and design strategies toward solution.	1) Report on this conference to ESE Director, State Health Officer, and Professional organizations. 2) Facilitate work group from groups and agencies above to address at least one issue of concern - possibly medication. 3) Focus on pilot or best practice project to get outcome indicators which document the cost/benefit ratio of providing adequate school health services. 4) Contact Dr. Nackashi for FL. Ped. support	3 mos.
23 KS Part H Fam svc Coord.	1) SSI continuing for families. Family resources have to be so small to qualify that we keep families disabled on order for them to keep Medicaid d/t SSI. 2) Poor supervision of medical/health related services in day care by day care providers as well as special education paraprofessionals assisting with children at community day care/preschools.	1) SSI will continue to be available for our families. Family resource amount family has will be re-evaluated to allow family to have proper housing and transportation. 2) Day care will have nurse assistance as needed and providers and paras for special children in these settings will be trained by a nurse.	1) I will draft a letter to legislators in Kansas voicing reason of needs of program as well as my concerns about limitations. I will encourage "my families" which I work with to write to legislators. 2) I will submit my concerns to the child care regulators in Kansas. I also will voice my concerns of lack of supervision in general of day care where families pay for a "level of care" but don't always get much. Concern related to inadequate training for special needs children will be addresses with Part H and Part B programs in my area and we will look at possible training programs.	3 mos.
Program staff CO Coord. CO options for inclusive care	Medication in child care in CO - some 10,000 licensed child care facilities are currently practicing nursing without license!	More centers, family child care homes aware and in compliance	1) Arrange meeting: Marie Swigert, Chris Perreault, Dana Andrews(licensing) and self to identify problem. 2) research : What have other states used? 3) Training for R&R staff: Treatment and other procedures require delegation. 4) Training for CDHS' Respite Care Programs: Treatment and other procedures require delegation.	3 days